HEALTH INFORMATION SUPPORT FOR URBAN WOMEN IN BIJAPUR DISTRICT

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Dr. Shobha Patil

UGC- Post Doctoral Fellow

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Mentor

Prof. P.G. Tadasad

Professor and Mentor

Department of Library and Information Science,

Karnataka State Akkamahadevi Women's University, Vijayapura

DEPARTMENT OF LIBRARY AND INFORMATION SCIENCE, KARNATAKA STATE AKKAMAHADEVI WOMEN'S UNIVERSITY, VIJAYAPURA

2019

Dr. Gavisiddappa Anandhalli
M.Sc.,M.Phil.,P.G.D.C.A., Ph.D
Associate Professor, Chairman and (I/C) Librarian
Mobile**:** +91 9448825666
Email **:** gavi.vijju@gmail.com

University Library
Karnataka State Akkamahadevi Women's University,
Vijayapura – 586108
Phone No. 08352 229221, 229049

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Prof. P.G.Tadasad
Professor and Registrar (Evaluation)
Karnataka State Akkamahadevi Women's University, Vijayapura

Librarian
Karnataka State Akkamahadevi Women's University, Vijayapura

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I further declare that the results of this research work have not been previously submitted for any other degree, diploma or such other similar titles, of this University or any other Universities in India or abroad.

Place: Vijayapura
Date: 02-05-2019

Dr. Shobha Patil
UGC- Post Doctoral Fellow

KARNATAKA STATE AKKAMAHADEVI WOMEN'S UNIVERSITY
JNANASHAKTI CAMPUS, TORAVI, VIJAYAPURA-586108
DEPARTMENT OF LIBRARY AND INFORMATION SCIENCE

Prof. P. G. Tadasad
Professor and Registrar (Evaluation)
Department of Library and Information Science

Ph: 08352 –229012 (O)
09448 –180973 (M)
e-mail: pgtadasad@gmail.com

Certificate

I certify that the report entitled **"Health Information Support for Urban Women in Bijapur District"** *submitted by* ***Dr. Shobha Patil*** *for the partial fulfillment of the requirements for successful completion of* ***PDF in Library and Information Science, Karnataka State Akkamahadevi Women's University, Vijayapura*** *is her original work carried out under my guidance.*

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Place: Vijayapura

Date: 02-05-2019

Prof. P. G. Tadasad
Professor, Registrar (Evaluation) and Mentor
Dept. of Library & Information Science
Karnataka State Akkamahadevi Women's University,
Vijayapura - 586108

Certificate

This is to certify that four publications in the form of articles on the research topic have been published in national and international reputed refereed journals and conference proceedings.

Prof. P. G. Tadasad
Mentor

Dr. Shobha Patil
UGC- Post Doctoral Fellow

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CHAPTER - 1

INTRODUCTION

1.1 INTRODUCTION:

Information is indispensable in every field of human efforts. The information is needed to take the decision possible – to select a garment, vote for a candidate, evaluate career opportunities, select a course, plan meals, choose a doctor. Such actions are common in our daily life. The information is required for taking proper decision about our health too. To keep good health and to remain physically fit, the knowledge on health is important. The citizen's awareness, up-to-date knowledge, timely access and use of information by them in the domain of health are critical (Maheswarappa and Bhadrashetty, 2015).

Health is a basic human right and is essential for a social and economic development. Increasingly, health promotion is being recognized as an essential of health development. For health development, health information is a vital tool to implement as per the strategic plans framed to benefit the entire community of the world. There are many sources of health information systems for different sectors of the society. Health may not be everything but everything without health is nothing. Thus World Health Organisation's (WHO) constitution proclaims, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. It means the attainment of the highest possible level of health by all. The prerequisites for health are peace, shelter, education, social security, social relations, food, income, the empowerment of women, stable eco-system, sustainable resource use, social justice, respect for human rights and equity. Above all poverty is the greatest threat to health (Srinivasan, 2002). Importance in the health status of the population has been one of the major thrust for urban development.

According to WHO, health information is information that contributes to knowledge and understanding that, in turn, provides part of the basis for making decisions in developing and managing services to improve health and health care (Sreelatha and Sangeetha, 2014).

Any piece of information on health domain constitutes health information. It deals with curative and prevention of diseases and healthy living of the human being. The saying `Health is Wealth` is relevant in all ages. The nation's wealth depends on people's health. So, the people's health is natural wealth of a nation. The World Health Organization's call `Health for all by 2000 AD' in 1977 is still relevant. Since, Nation's development depends on the health of the people, it is important for India to provide enough attention to health care and education programs (Balan, 1989).

Indian women have low levels of education and less participation in society. They have little autonomy, living under the control of their parents till marriage, then their husband, and finally their children. Women's status is often described in terms of their level of income, employment, education, health and fertility as well as the roles they play within the family, the community and society. Women's health is recognized as an important factor beyond from reproduction (Yadav, 2004).

Health of women is understood as a distinct way. Many factors are considered to measure the women health like physical and mental status, environmental, occupational, violence against women and social factors effecting her health, and families approach in caring complete family. These are all together converting the health. By observation we can understand that women's biological aspects and mental fitness with nutrient food is more important (Sujatha, 2017).

Health is an important area in which women need information as they should know how to take care of their personal health. They must be informed about various health care programmes to keep their children and other family members away from diseases (Sen, 2004).

Health information is disseminated by the professionals for different purposes in different modes. Health Information products and services are available, these cannot reach the end-users unless there is a good mechanism for disseminating such information. In our country, the information needed for rural and urban development, are disseminated by various agencies either through formal publications or through designated officials or through libraries and information centers.

In the context, libraries play a significant role in disseminating health information or creating health awareness among users at large. Libraries have been playing a vital role in disseminating health information to the society at large. Libraries particularly health based information system collect, organize and provide access to health related information and thus help the society in creating and disseminating health information/ awareness among the people.

1.2 OPERATIONAL DEFINITIONS:

The term 'health' is viewed differently by different people and authority all over the world.

Health: The WHO defined health as a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity (Callahan,1973).

Information: Fact or message conveyed or represented or recorded by a particular arrangement or sequence of things. Information refers to both substance and contents of documents and to physical existence, it is the cognitive state of awareness given representation in physical form.

Health information: The term is interpreted to mean health statistical, epidemiological and other health oriented data used in the planning and management of health services. For general public it can be interpreted as information on different areas and aspects of health care.

Health Information Literacy: According to Medical Literacy Association "Health information literacy is the set of abilities needed to; recognize a health information need; identify likely information sources and uses them to retrieve relevant information; access the quality of the information and its applicability to a specific situation and use the information to make good health decisions".

Health information support: Support services provided by information agencies or institution on health information.

Woman: An adult female person above the age of 18 years.

Bijapur District: One of the thirty districts of Karnataka state having headquarters at Vijayapura (Formerly known as Bijapur district with headquarters at Bijapur) having jurisdiction over five talukas namely Basavan Bagewadi, Vijayapura, Indi, Muddebihal and Sindagi (Bijapur District, 2015). Now the district has been reorganised into twelve talukas namely Vijayapura, Basavan Bagewadi, Indi, Muddebihal, Sindagi, Talikote, Chadchan, Devar Hipparagi, Kolhar, Nidagundi, Babaleshwar, Tikota with effect from November 1, 2017.

1.3 NEED FOR THE STUDY:

Health awareness is a process which effects changes in the health practices of people, knowledge and attitude related to such changes. Health awareness is closely connected with imparting of knowledge to the people about the principles of hygiene. It educates people for preserving and developing their physical and mental health. Health awareness is a basic pre-requisite for leading comfortable life. It is true that, one should not diagnose on their own, but at least one can take precautions to keep the routine disease away by reading health related information. In the context, library and information centre plays a significant role in disseminating or creating health awareness among society at large.

Women an important component of a society - a least beneficiary in view of their illiteracy, limited exposure to the outside world, poor communication and expression abilities and very limited or no access to information sources find it very difficult to use the information they require. The most essential step under the circumstances is to understand completely the information seeking behavior of women in their socio-economic and cultural contexts. Women are mainly reached by indirect methods, usually through extension services. Even if the information is made available to the woman, the willingness of her to change, her ability to interpret and use information and the credibility of information are the key factors in making any impact of information on their well being.

Access to information would certainly enhance the capability of the individuals to make better use of the resources, take considered decisions and improve her quality of life. But women suffer from certain inherent problems viz., health, poverty, illiteracy, locational remoteness, male dominated families where she is

denied exposure and access to information, which is crucial for her development as well as her family. Women lag behind in every sector. Obviously the nation cannot move ahead keeping the major portion of its population in dark. As a result, International organizations, various state and central Governments, NGO's and many corporate sectors are making efforts to provide information support to urban women (Chatterjee, 2003).

A literature search made on LISA+, LISTA, Emeraldsight.com, and subject bibliographies (Prasher,1971; Sewa Singh and Malhan, 1986, 1988, 1991,1994; ILSA,2003; Keys Young, 2002) indicates that number of studies have been reported from abroad including India. Majority of the studies conducted by developed countries highlight on health care support (Donner, 2001; Brown, 2005) - food and nutrition, AIDS, fighting breast cancer, menopause disorders, etc. Studies also have been conducted to support women with information on safe sex, use of condoms (Kerrigan, 2002), security (security4women.com, 2008), gender discrimination (Anita, 2004), etc. On the contrary, the literature from developing countries reveal that studies on information support to women with regard to community information – general health problems, use of fertilizers and manures, food and agriculture (wiig.worldpress.com; agroinfo.org; infs.ukzn.ac; ruralwomen.org), use of IT and gender responsive technology (Obot, 2005; Huyer,1997), etc. Swarnalatha devi (1995) highlighted on rural and urban community's attitude towards local newspaper, health information and agricultural information.

It is felt necessary to study these aspects in the present study. Hence, it is proposed to examine health information support for urban women in Bijapur district. The study is also proposed to examine the health awareness and use levels of the urban women as regards information support programs initiated by various agencies.

The success of a nation in providing essential information support to its citizens is contingent upon the availability of resources and infra-structural facilities. The adequacy of the information support programs will enable the concerned to provide effective information services. The effective planning of any kind can never be achieved unless it is made known where it stands.

The information is required for taking proper decision of about our health too. To keep good health and to remain physically fit, the knowledge on health is important. The citizen's awareness, up-to-date knowledge, timely access and use of information by them in the domain of health are critical (Maheswarappa and Bhadrashetty, 2015). In modern days, the spread of health information to different sections of the society takes place through television, radio, print materials, cinema, public speeches, and posters; door-to door canvassing and Internet.

Women's health literacy promotion needs to play a crucial role to ensure these factors. Women's health literacy should bring about a change in women's lives, make women independent seekers of health related information. In the context of India, as well as Karnataka where women are known to be socially economically disadvantaged compared to men, a gender perspective on health is of prime importance. A gender perspective on health recognizes difference in the health status of women and men, in the type of their diseases and ailments. The reasons arise from their different biological, social and economic conditions. Social and economical factors decide people's health seeking behaviors. Socio economic conditions determine how people approach health education (Sujatha, 2017). In this context, an attempt has been make to study the health information support for urban women in Bijapur district (Now Vijayapura).

1.4 STATEMENT OF THE PROBLEM:

"Health Information Support for Urban Women in Bijapur District"

1.5 SCOPE AND LIMITATIONS:

The study population comprises of urban women in Bijapur District (Now Vijayapura), Karnataka state. According to the census of 2011, Bijapur (Now Vijayapura) had population of 2,177,331 of which male and female were 1,111,022 and 1,066,309 respectively. With regards to sex ratio in Bijapur, it stood at 960 per 1000 male. Out of the total Bijapur population 23.05 percent lives in urban regions of district. In total 501,978 people live in urban areas of which males are 253,460 and females are 248,518. Sex Ratio in urban region of Bijapur district is 981 as per 2011 census data.

The scope of the present study is limited to the study of health information support for urban women in Bijapur district (Now Vijayapura). A study population was chosen adopting stratified sampling. The population is chosen from Bijapur district which is divided into five talukas i.e., Bijapur, Basavana Bagewadi, Sindagi, Indi and Muddebihal. The urban women from this Bijapur city, 35 wards are selected and interviewed to assess their health information needs and gathering habits.

The present study is mainly based on the primary data collected from sample respondents and the following limitations have been identified.

The present study is restricted geographically to the sample population of urban women identified using the sampling method in Bijapur District (Now Vijayapura). It is geographically confined to Vijayapura city. Further it is restricted to the extent of assessing the health information needs, awareness and use level and analysis of existing information support programmes. The limitations of the methodologies adopted also apply to the study.

1.6 OBJECTIVES OF THE STUDY:

Primary objective of the study is to examine the health information support for urban women in Bijapur District (Now Vijayapura). Specifically the objectives of the study are:

1. To identify the health information needs of urban women.
2. To identify the information sources that urban women use, to meet their health information needs.
3. To identify the health information support programmes.
4. To understand the nature and extent of health information support system.

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CHAPTER - 2

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION:

The purpose of this chapter is to explain how the research was conducted and data was gathered. The present work is an effort to know situations of health information support for urban women in Bijapur district (Now Vijayapura). Hence the research work is carried on to:

- Know the health information needs of urban women and awareness level of women as regards the health information support programs.
- Know the use level of urban women as regards the health information support programs.
- Identify, the existing health information dissemination mechanism and health information support programmes existing in the Bijapur District (Now Vijayapura) and to propose suggestions for improving the existing health information support programs.

There are three parts of a research design - observational, sampling and operational design. Each of them is described in the following sections.

2.2 OBSERVATIONAL METHOD:

The research study undertaken is exploratory in nature aimed at knowing the current status of health information support for urban women in Bijapur district (Now Vijayapura). The procedure adopted to construct the observational method for the present study are as follows.

- **Problem statement, purpose and benefits:** The research problem was identified by scanning the secondary and primary information resources with possible objectives and in what way the study would benefit the society at large.
- **Theory, assumptions and background literature:** The existing literature concerned to the research problem and established theories available to substantiate the significance of the study in question.

- **Conceptualization of the terminology:** Clear understanding about the research problem and concepts appearing of the research problem by referring dictionaries and encyclopedias is carried out.
- **Review of the Literature:** Comprehensive literature is called out on the research problem by scanning full text journals and abstracting databases both offline and online resources.
- **Designed specific objectives of the study:** The specific objectives of the study are framed.
- **Construction of research design:** Keeping in view the objectives of the study, questionnaire was developed and pre-tested. Based on the feedback and suggestions, final questionnaire has been designed.
- **Quantitative research study:** The selection of sample respondents has been made from Bijapur district (Now Vijayapura). From Bijapur district, 35 wards have been selected for this study. From each ward 20 respondents have been selected. Thus Total 35 wards and 700 respondents have been selected for this study. For every ward twenty women have been identified by using stratified sampling.
- **Data collection and analysis:** Data collected has been tabulated and interpreted.
- **Summary of Findings, Recommendations and Conclusions:** The results of the study are summarized in the form of findings and recommendations have been made based on the results of the study.

A schematic design depicting the overall design for this research work is shown in the form of flow chart in Figure 2.1

Identification of general research problem on Health Information Support for Urban Women
Collected Literature Review
Research Problem – Health Information Support for Urban Women in Bijapur District (Now Vijayapura)
Literature Review
Objectives of the Study
Development of Research Tools
Pre-tested the Research Tools
Re-designed Research Tools and collected data
Summary of Findings, Recommendations and Conclusion

Figure 2.1: Schematic Design of Research Study

2.3 SAMPLING DESIGN:

The study population comprises of the urban women in Bijapur district. Bijapur city renamed as Vijayapura, is the district headquarters of Bijapur district of Karnataka state. Bijapur district (Now Vijayapura) consists of five taluks viz., Basavana Bagewadi, Indi, Muddebhihal, Sindagi and Bijapur. The city has population of 326,360 as per 2011 census among which male population is 1,65,122 and female population is 1,61,238.

Bijapur (Now Vijayapura), one of the popular heritage cities located in the Karnataka state in India is also one of the top ten populated cities in Karnataka. Bijapur is a border district of Karnataka state. Bijapur is considered as an industrially backward district. The major reasons for its backwardness are lack of adequate initiatives, poor infrastructure, scarcity of water, absence of mineral resources and poor connectivity. Geographically, the district lies in the tract of the Deccan Plateaus. The lands of the district can be broadly divided into three zones: the northern belt consisting of the northern parts of Bijapur taluks of Indi and Sindagi; the central belt consisting of Bijapur city; the southern belt consisting of the rich alluvial plains of the Krishna Rivers parted from the central belt by a stretch of barren Trap.

Since Bijapur is district headquarter, here the urban population is high. Here the proportion of slum population is also high. In Bijapur taluk the urban population is 45.41 percent which is maximum. In Bijapur district, there are six local bodies. Bijapur has a city municipal council and Basavana Bagewadi, Indi, Muddebhihal, Sindagi and Talikoti are having town municipal councils. In Bijapur city, there are 35 wards and each ward has one member. In total, there are thirty-five members out of which 23 male and 12 female members. Category-wise details are: 8 backward class members, 4 SC, 1 ST and 18 general category members.

The selection of sample respondents has been made from Bijapur district (Now Vijayapura). From Bijapur district, 35 wards have been selected for this study. From each wards 20 respondents have been selected. Thus total 35 wards and 700 respondents have been selected for this study. For every ward twenty women have been identified by using purposive sampling and interviewed for the purpose of study.

2.4 OPERATIONAL DESIGN:

Survey of the published literature on health information was carried out. Secondary and primary sources of information were consulted to identify the major facets of health information. Journals articles and textbooks relating to health information were scanned. A retrospective search of literature on the topic was undertaken to identify the studies on the use of health information. Preliminary discussions were held with the public to identify the health information sources at the local level. Finally, five sources of health information were identified. They are television, radio, printed materials, human resources and institutional sources.

All the newspapers local, regional and national were scanned to see the schedules of TV and radio programs on health. Five types of programs related to health were identified on TV and Radio. They are news stories, public service announcements, talk shows, advertisements and special programs. An attempt was also made to identify the specific health programs telecasted on TV and Radio.

All India radio, Bijapur (Now Vijayapura) were consulted but no specific information regarding health programs were available as some programs are completely devoted to health and some have health programs as part of other programs and scanning the programs of TV channels in newspapers identified few programs related to health.

While scanning newspapers, it was also found that some newspapers have separate sections on health. Likewise printed materials such as general magazines covering topics on health and health magazines were also identified. The specific sources coming under human and institutional sources were also identified. It was decided to measure the use of information sources on a 1-4 scale where 1 indicates ‘None’, 2 = Little Extent, 3= Some Extent and 4=Greater Extent.

The structured questionnaire is used to gather information from the urban women of Bijapur district. The schedule consisted of background information of respondents and set of questions on information needs, radio, television, print materials, human, and institutional sources. For the purpose, we scanned all the leading newspapers in English and Kannada. Identified five types of programs namely, news stories, public service announcements, talk shows, advertisements, and

special programs on television and broadcast through radio. We also identified the special sections of newspapers, general magazines, and health magazines, human and institutional sources on health. The questionnaire was structured keeping in view the objectives of the study and data processing needs.

Primary and secondary sources were used for data collection. The secondary data helped to provide a framework and insight based on previous studies on the health information need of urban women. Specific data collecting instruments included questionnaires, literature review.

The questionnaire included questions on personal data (name, age, marital status, literacy level, occupation, income, etc). Other questions included in this questionnaire asked for information on their information needs, use of mass media, knowledge of understanding health problem and awareness of government programmes.

An in-depth analysis of the topic of research was made to identify the major facts and the sub facets. Specific variables to be measured were identified. Taking into consideration the objectives of the study and the discussions made with respective groups. Questionnaire has been designed in English language, keeping in view the objectives of the study. The questionnaire is divided into five parts. Part I- General information, Part II - Health information needs, Part III - Mass media, Part IV - Knowledge of understanding health problem, Part V - Awareness of Government Programmes.

First part stresses on general characteristics and emphasis on urban women.

Second part stresses on health information needs and gathering habits of urban women. This part emphasizes on awareness of various types of health information or health information needs of urban women. Health Information needs of urban women indicate women health problems.

Third part highlights on various information support programs disseminated through different channels. Preferred sources for gathering health information like Radio, Television, Newspaper, Magazines, Human Resources, and Institutional Resources, Internet, E-Resources and use of libraries and learning materials for getting health information. These channels highlight various women related programs.

Fourth part indicates knowledge of understanding health problem and Fifth part indicates various Government schemes related to women and their awareness and women's problems in getting the related information are emphasized in the Questionnaire.

Pilot Survey:

To test the relevance of questions in the questionnaire, a small representative group of women (ward wise) from all demographic categories within the proximity of Bijapur district (Now Vijayapura) was conducted. One ward was considered for pilot survey in Bijapur district (Now Vijayapura). After the response of the respondents, each question was examined to identify the possible problems in answering the questions. Suitable solutions were worked out and modifications were made and the final questionnaire was prepared.

Final Survey:

Once the final questionnaire was ready for distribution, the final survey was conducted for five months from April 2016 to August 2016. The questionnaire were distributed and collected from different colonies of 35 wards in Bijapur district. From each ward 20 respondents have been selected and personal visits were made to the houses, university and working environment to collect the data. Thus total 35 wards and 700 urban women were identified and conducted the final study and data has been analysed with the help of SPSS.

Questionnaires were distributed and collected as mentioned below.

Table 2.1: Details of Final Survey

Sl. No	Wards of Bijapur city (Now Vijayapura)	Selected Respondent	Responded
1	Bijapur Ward No -1	20	20
2	Bijapur Ward No -2	20	20
3	Bijapur Ward No -3	20	20
4	Bijapur Ward No -4	20	20
5	Bijapur Ward No -5	20	20
6	Bijapur Ward No -6	20	20
7	Bijapur Ward No -7	20	20
8	Bijapur Ward No -8	20	20
9	Bijapur Ward No -9	20	20
10	Bijapur Ward No -10	20	20
11	Bijapur Ward No -11	20	20
12	Bijapur Ward No -12	20	20
13	Bijapur Ward No -13	20	20
14	Bijapur Ward No -14	20	20
15	Bijapur Ward No -15	20	20
16	Bijapur Ward No -16	20	20
17	Bijapur Ward No -17	20	20
18	Bijapur Ward No -18	20	20
19	Bijapur Ward No -19	20	20
20	Bijapur Ward No -20	20	20
21	Bijapur Ward No -21	20	20
22	Bijapur Ward No -22	20	20
23	Bijapur Ward No -23	20	20
24	Bijapur Ward No -24	20	20
25	Bijapur Ward No -25	20	20
26	Bijapur Ward No -26	20	20
27	Bijapur Ward No -27	20	20
28	Bijapur Ward No -28	20	20
29	Bijapur Ward No -29	20	20
30	Bijapur Ward No -30	20	20
31	Bijapur Ward No -31	20	20
32	Bijapur Ward No -32	20	20
33	Bijapur Ward No -33	20	20
34	Bijapur Ward No -34	20	20
35	Bijapur Ward No -35	20	20
	Total	**700**	**700**

Questionnaire have been distributed and collected from urban women in Bijapur District (Now Vijayapura) and data has been analysed.

2.5 CHAPTERISATION:

The present study has been divided into six chapters viz.

Chapter-1: Introduction: In this chapter an attempt is made to justify the need for the study and statement of the problem is provided. It also brings out the scope and limitations, enumerates the objectives of the study.

Chapter-2: Research Design and Methodology: Factors considered in identification of the observational method, sampling design and operational design followed for the pilot as well as for the final survey. At the end chapterisation of report is given.

Chapter-3: Health Information Support for Urban Women: Review of related Literature: This chapter provides a brief review of related literature on health information support for urban women.

Chapter-4: Health Information Support Programmes for Women: Health information dissemination mechanism, Health information support programmes in the Bijapur district (Now Vijayapura) are identified in this chapter.

Chapter-5: Data Analysis: It includes the description of the data, their analysis and results obtained. In essence this chapter presents the entire data and their analysis drawing results from them.

Chapter-6: Summary of Findings, Recommendations and Conclusions: A brief summary of the findings based on the survey results and discussions is enumerated and also provides areas of further research, recommendations and conclusions of the study.

A bibliography arranged alphabetically by author's name is provided at the end.

Appendices:
Appendix-I: Notification of revenue Secretariat, Government of Karnataka
Appendix II: Structured questionnaire used for the study.
Appendix III: Four research publications have also been appended at the end.

2.6 REFERENCES

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CHAPTER - 3

HEALTH INFORMATION SUPPORT FOR URBAN WOMEN: REVIEW OF LITERATURE

3.1 INTRODUCTION:

This chapter presents the literature that has been reviewed in relation to the health information support for urban women. The health information needs and seeking of information of women as well as the information available to them are examined. The primary focus of the review is to identify the research conducted on women's health information and help-seeking behaviour.

Retrospective search was undertaken using LISA, LISTA, EBSCO, J-Gate, Emerald, Sociofile, Psycholit, ERIC, and PubMed, thesis and dissertation, Government publications. Many studies have been reported at the international level and national level. The literature reviewed is detailed in the following sections.

3.1.1 Health Information Needs:

O'Loughlin (1988) described women's information switchboard, in South Australia, which was established in 1978 to provide concrete, unbiased information and to act as a referral centre to meet the needs of women. *Northup et al.,* (1990) suggested to increase community participation in decision making and adopt local needs by political groups, improved communication with institutions, dialogue with traditional healers, dialogue with mothers, and meeting with community representatives, and for effective communication within the community and improved training methods for mothers and health care providers.

Graydon et al., (1997) assessed the information needs of 70 women with breast cancer being treated by surgery, chemotherapy or radiation therapy. All women had high information needs, irrespective of type of treatment received. They mainly wanted information about their disease, treatments and investigative tests. An examination of individual items on the TINQ-BC revealed that all women wanted to know if the cancer would come back and how to tell if it had recurred.

Naidu and Chandrlekha (1998) pointed out that people must have a deep understanding of their needs and problems and that education and development are an internal process that occurs only in equal partnership.

Barker and Polson (1999) examined a consumer health information project: Best health, sponsored by the Highland Health Board, Scotland and based in Inverness, which caters to the health information needs of the widely dispersed population of the Scottish Highlands. Most people use the service to become better informed about a specific personal health problem. The users are highly satisfied with the service and the information provided, and some areas which could be developed are identified.

Swanson (1999) found that there is lack of needed medical care for women under use of preventive services, depression and low self-esteemed, abuse and poor physician communication. *Schneider* (2000) discusses the skills women need to become active, responsible advocates for their own health: effective communication techniques, finding the qualifications of their doctors and hospitals, personal medical record keeping, legal rights and responsibilities, insurance options, and how to access additional health information.

Watts et al., (2004) depicted breast health information needs of women from minority ethnic group's background. Access to a range of appropriately designed high quality, culturally-specific and sensitive health information is needed. For women from minority ethnic groups to make informed decisions about their health and particularly about whether to participate in breast cancer screening programmes.

Jiyane and Ocholla (2004) reported on a study, which explored the information needs of the rural women and how they are fulfilled in the area of Melmoth, KwaZulu-Natal. The researcher found that there is a need for suitable information on agriculture, health, education, business, legal and career opportunities as well as self-help related activities.

A study of 119 women by *Procaccino and Warner* (2004) assessed the process of seeking health information (women's health information needs, the search strategies they employed for filling the information need, and the use of the health information found), and their awareness of specific health and medical information resources. There is a low awareness by respondents of specific health and medical information resources.

Mooko (2005) investigated the information needs and information-seeking behavior of rural women residing in three non-urban villages in Botswana. The family situations that led women to seek information included health, agriculture, employment, family violence and basic needs for the family. In addition, the women needed information on government aided funding, welfare subsidies and policies, and training. *Barnoy, Bar-Tal and Zisser* (2005) examined information exchange patterns between 98 married couples in Israel where one is a cancer patient and the other is the main caregiver. The results demonstrated that in the context of cancer patients and their spouse as caregivers, neither partner considered the informational needs of his or her spouse.

Forty women living in a rural part of Ontario, Canada were interviewed by *Wathen and Harris* (2006) using a semi-structured interview guide. They were asked about their health information seeking for both chronic and acute concerns. There are unique challenges and enablers to health information seeking for women living in rural areas, including the role of formal, informal and ICT-based information intermediaries.

Ankem (2007) studied retrospectively tracked women from the beginning of their illnesses and analyzed their information-seeking behaviors. A preliminary model of information seeking showed that while friends, magazines and television made several of the women aware of the new procedure, the internet was heavily utilized for learning about treatment options. Researcher conclude that health sciences librarians may inform women about their health and treatment options by guiding women to easily readable, authoritative and reliable information sources, including web information sites.

Kontos, Bennett and Viswanath (2007) observed that, despite the increasing of the internet and amount of online health information, there are significant barriers that limit its widespread adoption as a source of health information. *Musoke* (2007) investigated the accessibility and use of health information among primary health care providers. The researcher focused on women and health worker's experiences with information in rural Uganda. *Dobbins et al.,* (2012) met consumer health information needs can be a challenge. Researcher suggests that women seek health information from a variety of resources.

Mukherjee and Bawden (2012) investigated the everyday health information-seeking practices of a small group of the 'general public' and the implications for information-seeking theory and health information provision. *Richey* (2012) observed that high school librarians have the potential to give sexual-health information needs of their adolescent patrons, thereby contributing to a healthier society. *Genuis* (2012) focused on information behavior in a context where medical evidence is explicitly evolving (management of the menopause transition), this investigation explored how women interact with and make sense of uncertain health information mediated by formal and informal sources.

Zach et al., (2012) discussed the relationship between health information seeking, patient engagement and health literacy. The findings suggest that lack of access to the Internet in itself is not the primary barrier to seeking health information in this population and that the digital divide exists not at the level of information access but rather at the level of information use.

Enwald et al., (2012) explored through an interdisciplinary approach the potential to tailor health information on the basis of human information behaviour (HIB) on par with the results of basic physiological measurements of individuals' health. *Dalrymple et al.,* (2013) described an approach that used enhanced text messages to encourage health information seeking during pregnancy. *Omotoso, Bello and Akadiri* (2013) analyzed the health information needs of youths in Africa. This study investigates the healthy information needs of Nigerian undergraduates in selected universities in Nigeria.

3.1.2 Library services:

Harris (1992) highlighted the public demand for health and sickness information was measured in Wellington public library, New Zealand. This increasing demand of present's public libraries with an opportunity to provide relevant services to a wider public. *Materia et al.,* (1994) pointed out that dissemination of information at the district level in developing countries is hampered by an acute shortage of teaching materials and health information resources and also the lack of accessible libraries to potential users.

Gollop (1997) explained the ways in which urban, older, African American women obtain health information and some of the factors that influence such activity. It is found that respondents receive health information from their physicians, the mass media, members of their social networks and indicated that members of this population have a highly positive perception of the public library, although only a small segment use the library regularly.

Kirton (1998) experienced that, a lending library residing under the umbrella of education service within the locality and aims to promote health through the providers of health information. *Gross* (1999) highlighted that, many health care consumers have become their own advocates in seeking information and consumer's choices vary from the internet, news media, national and local associations, the public and health sciences libraries, to a growing number of consumer health libraries.

Connor (2000) analyzed selected web sites on women's health, mentions notable websites developed by several medical libraries, showcases specific resources for finding information, and discusses criteria for evaluating and critically examining web sites. *Marton* (2001) described the development of an environmental scanning system by a group of academies and health librarians for the purpose of conducting a consumer scan on women's health information resources on behalf of Ontario women's health council, Ontario ministry of health and long-term care.

Muller (2002) reported the findings of research conducted in the public library of the Swiss cancer league in Berne, Switzerland, to ascertain whether more books are published for women with cancer than for men with cancer. These demonstrate that while there are more male cancer patients the bulk of books are written for women.

Allison (2007) covered the concept of gender-specific medicine, as well as specific ways that librarians can become important players in getting gender-specific biomedical research information translated to real world application.

Kelly (2012) explored the role and expectations of patrons and staff about the role of a public library in enabling citizens' "health information work". It is found that library staff had no training in supporting health information and limited or no knowledge of authoritative online health resources and how to use them, and their approach to internet searching was similar to users.

Featherstone et al., (2012) provided an understanding of pandemic information needs and inform professional development initiatives for librarians in disaster medicine. Health care administrators were identified as a key audience for pandemic information, and news agencies were utilized as essential information sources. Librarians' skills at evaluating available information proved crucial for selecting best-quality evidence to support administrative decision making. *Fountain* (2013) provides a case study of the information environment in the national women's health network, a women's health interest group, to help librarians facilitate nuanced discussions with students on the applicability of interest group literature inside and outside of the university classroom.

3.1.3 Internet/Website based services:

Marton (1998) compared internet resources that have their origins in Canada and the USA designed by women's groups with those created by government, universities, hospitals and the corporate sector in terms of the quality and breadth of health information provided. *Gillaspy and Huber* (1998) observe that since women's experience of HIV disease differs significantly from men's, and their prevention needs are also different, a need for female specific internet information exists.

Chu et al., (2009) described how health communication project measured the psychosocial influences of computer anxiety, computer confidence, and computer self-efficacy in older adults at six meal congregate sites. The adults completed a five-week education intervention, based on Bandura's self-efficacy model, designed to assist older adults in retrieving and evaluating health information resources on the internet. By engaging older adults in the use of internet health information resources

to better contribute to their health, independence, safety, and wellness, the status can be improved.

Huber et al., (2003) described the woman to woman: community health information project facilitates information access at selected community-based women's health agencies in Houston, Texas. Findings indicate that academic and community-based organizations can collaborate effectively to increase women's access to electronic health information.

Survey done by *Marton's* (2003) revealed 13 types of health information sources in terms of their perceived relevance and reliability. Health care practitioners, books and pamphlets/fact sheets received high ratings on both attributes of source quality.

Kittler (2004) surveyed 500 randomly selected patients from two ambulatory primary care clinics affiliated with the Brigham and women's hospital in Boston, Massachusetts. Respondents reported trusting information from physicians the most and information from health websites slightly more than information from any traditional media source. Over half of those searching the internet reported changing their behaviour as a result of information found online.

Yoo and Robbins (2008) investigated how and why middle-aged women use health-related web sites. The results show that a middle-aged woman would be more likely to go to health-related web sites if she has a more positive attitude, stronger motivations concerning gratification, and more confidence regarding her ability to use health-related web sites.

Collins and Sasser (1998) found that popular media and the internet, has highest consumer in health information, accessible free of charge via the internet. *Dracos and Seta* (1998) draw the attention to a wide variety of medical and health care information available on the world wide web in the style easily understood by the public. They recommended bringing out rules and regulations to validate the reliability, completeness and consistency of the information sources.

Atkinson, Saperstein and Pleis (2009) examined the prevalence and predictors of participation in specific online health-related activities. The internet was most widely used as a health information resource, with less participation in the purchase of medicine and vitamins and in online support groups.

Semi structured interviews conducted by *Marton* (2010) on health information seeking on the web conducted with five women who have chronic mental health conditions demonstrate that several criteria are utilized to assess the reliability of online health information during online searching.

Renahy, Parizot and Chauvin (2010) surveyed 3720 residents of France who had searched for health information during 12 months. This study reveals different uses of the internet for health information seeking (HIS) between men and women and between the general population and people who work in the health sector.

Kim and Yoon (2012) examined the use of an online health forum by married Korean women living in the USA who sought help for health and medical issues with the help of a thousand messages posted to a health forum designed for married Korean women living in the USA. It was observed that women were for recommendations of hospitals or doctors, including doctors who can speak Korean; seeking to know the cause of the symptom they were experiencing, or wanting to learn about treatment methods before consulting a doctor.

Tewell (2014) determined whether there is a significant relationship between patients' frequency of internet use and their health care information and decision-making preferences. It is found that internet use frequency is associated with an overall preference for obtaining health information and participating in decision making.

3.1.4 Mass Media

Desai and Mehta (1976) found that the clinic is the best place to motivate young mothers. It has been established that mass media is an effective channel of communication to sensitize the people on any aspect. *Ngimwa, Ocholla and Ojiambo* (1997) examined the level of media accessibility and use by the Kenyan rural women in the Kinangop area. The study revealed that women require mainly health and

agricultural information. In the user survey conducted by *Gunter et al.,* (2003) just under one in four respondents had reportedly used the DiTV service in Birmingham, UK.

Liao and Yueh (2012) reported that ‘‘health service information’’ and ‘‘prevention health care information’’ were the most needed and important. Family, friends and television were the main channels for accessing health information. However, fewer respondents actively sought health information. When health problems occurred, they tended to seek direct medical treatment. Researcher identified that men were more attentive and active in seeking health information. Respondents over 75 years old rarely concerned about their health information need. People with more education were also more aware of their health information needs and more attentive to information disseminated via mass media.

Laslie (1981) opined that mass media provides a relatively rapid, inexpensive, and effective means of dissemination. *Konde-Lule et al.,* (1992) found radio as a potential channel for health workers. *Elkamel* (1995) pointed out TV as one of the most cost effective and easy method for dissemination of health education. *Kotehabhkdi* (1995) found video as in effective tool for successful change in behaviour of mothers to engage and continue to breast feed infants.

Kuncar (1995) opined that radio was suitable for providing health awareness by creating simple and accessible health messages and also using drama as an educational resource. *Valente et al.,* (1996) found that the mass media is effective in information dissemination, which increases knowledge about innovations and interpersonal communication facilities, behaviour change for allowing adoption of the innovation.

The findings of the study by *Mathiyazhagan et al.,* (2007) revealed that tribal’s tend to believe in interpersonal communication as compared to other modes of communication; availability of electronic media viz. radio and television with the tribals is limited, however, their accessibility to these media is somewhat better.

3.1.5 Magazines

Elliott (1994) noticed that women's weekly magazines are read by approximately half of the women in Britain and by several million men as well. Although these magazines represent an important source of health information for their readers, there is virtually no research which examines the content of the information provided and covers a descriptive analysis of the content of 8 popular women's weekly magazines over a 4 week period.

Sunita (2010) found that health magazines are read by over 55% women in India although potentially these magazines represent a major source of health education and information for women, relatively little attention has been paid to assessing this role.

3.1.6 Government:

Harris and Wathen (2003) described various models of community health information delivery exist in Canada. Spiralling health care costs have many governments seeking to promote more judicious (and presumably more cost-effective) use of health care by consumers. One such method is through centralized, government-run health information services that rely heavily on information and communication technologies (ICTs).

3.1.7 Health Information Resources

Davies and Bath (2002) described the main maternity information sources used by Somali women living in a northern city in the UK. Sources of information emerged as a sub-theme from the data. Women sought and used information from several interpersonal sources. Many were dependent on general practitioners and health visitors for maternity information, although participants favoured community health forums addressed by health professionals. Women also sought maternity information from friends and neighbours.

Chatterley et al., (2012) observed that healthcare practitioners in Alberta and across Canada have varying levels of access to information resources depending on their institutional and professional affiliations. It is found that there is considerable

variation in the number of electronic resources and the levels of information support provided by professional health associations in Alberta and Canada.

Annet, William and Bamuhiiga (2012) studied electronic health information resources (e-resources) usage in three universities offering medical education in Uganda. One of the objectives of the study was to investigate factors influencing utilisation of e-resources, E-resources are important in medical education because they support study and research. Addressing their utilisation therefore improves library services, study, research and ultimately, healthcare. *Sakai* (2013) identified the most significant readability factors and examines ways of improving and evaluating Japanese health information text in terms of ease of reading and understanding.

3.1.8 Health Education

Chandrasekaran et al., (1965) conducted a survey of 10 clinics in the Greater Bombay area regarding contraception, found that there is no relationship to income, education or mother tongue in its use. The health seeking behavior of women depends on the accessibility, autonomy, and cost of care and more importantly availability of female doctors to attend to them.

Lenart (1987) suggested for education of ten basic programme teaching national philosophy or mutual self-help, nutrition, clothing, housing and home economics, education and crafts, health promoting cooperatives, conservation of the environment; and domestic planning. *Ewing* (1989) suggested educating people in taking responsibility for their own health, and a new holistic concept of health involving prevention rather than cure of symptoms. *Grant* (1991) suggested that the movement advocating healthy changes.

Goodwillie (1992) introduced culturally sensitive and attractive nutrition teaching aids consisting set of 13 nutrition education books dealing with food and diseases, food preservation, fitness, gardening, budgeting, developing training materials and individual food needs of family members. *Ratnaike and Chinner* (1992) recommended using key persons (advisory team, community health education unit, community health workers (CHW's) and women groups) in the system. *El*o (1992) found that lack of access to care in the outlying rural areas supersedes maternal

education, it was also indicated that maternal education has a profound effect on seeking medical care.

Singh et al., (1993) assessed the effectiveness of distribution of health education pamphlets among mothers with infants admitted to the pediatric ward of Christian medical college, Ludhiana, India. It is recommended that hospitalization was the appropriate period for when mothers to be are receptive to health education messages, thus derive advantage for distribution of health information materials to visiting population such as friends and relatives of patient, to make materials reach easily.

Kussel (1994) found that nurses proved to be the most successful health educators in changing the woman's behavior and girls often communicated health messages to their mothers while helping with household chores. *El-Katsha and hatts* (1994) suggested disseminating simple hygiene messages in health units, schools, and homes by health promoters (nurses, school teachers, and women leaders).

Cardaci (1994) highlighted that the level of schooling and age were not significantly related to variables such as knowledge on use of contraceptive methods, family size number of offspring and/or abortions, lent of breast feeding period and self-medication. *Kreun et al.,* (1995) recommended for strengthening of primary health care delivery system by broadening the scope of traditional IEC, leadership to a growing number of health education officers and developing a partnership with the private sector.

Felix de souse (1995) suggested that training should be a collective action, to overcome negative attitude toward health. The importance, of nutrition, of treating skin diseases and diabetes, and managing stress, blood pressure control, treating circulation problems, eating better, exercising and preparing home medicines was highlighted.

Campero-Cuena (1996) showed that the social situation of women is clearly correlated with their morbidity and mortality, while other studies demonstrate that statistical reports on women health are influenced by gender. *Kemprecos et al.,* (1996) suggested to create a village profile and plan for health education, disease prevention and improved water and sanitation and to provide information on beliefs and practices relating to hygiene and disease.

Ratna; Sarbani and Sahabata (2009) discussed the initiatives taken to advance women's health literacy, to support women's health protection and to organize health related information for its better access by health science libraries and libraries of centers for women studies in West Bengal, India. It is observed that specialized health science libraries and libraries of centers for women studies are helping Governments in population policy making, women's health, and health education, providing health information services and providing access to health information.

Thassri et al., (2000) suggested including obstetricians, nurses, nutritionists, health educators and health promoters, in health care delivery system, particularly of community contact point and rural level, health workers play a major role in guiding and educating people in use of health services.

Rukwaro and Otike (2012) discussed factors affecting the provision of information on sexuality and reproductive health to girls in secondary schools in Kenya. Suggestions include drawing up of national guidelines on sexuality and reproductive health education; training and equipping teachers, parents and peer counsellors with knowledge and skills on reproductive health, having appropriate reproductive health information disseminated through the mass media, libraries and health clinics; and efficient coordination of reproductive health provision among others.

Hodgens, Sendall and Evans (2012) examined post-graduate health promotion students' self-perceptions of information literacy skills prior to, and after completing PILOT, an online information literacy tutorial. Post-graduate students at Queensland University of Technology enrolled in PUP038 New Developments in Health Promotion completed a pre- and post-self-assessment questionnaire. The results from

four years of post-graduate students' self-assessment questionnaires provide evidence of perceived improvements in information literacy skills after completing PILOT.

3.1.9 Women health issues:

Heiberg (1996) reviewed the information resources relating to women's health for four different age periods: infancy and childhood; adolescent girl; the reproductive years; and old age. It is found that sex specific analyses of the safety and efficacy of drugs will be required as part of all new drug applications and that it will no longer be recommended that women of childbearing potential be restricted from participating in the earliest phases of drug trials.

Sheldon-Keller et al., (1996) found that the need for services in rural settings is no less diverse than in urban settings, but access to and provision of an adequate range of health care services typically is much more difficult. *Bae* (1997) found abundant evidence concerning urban-rural differences in access, availability, staffing and quality of health care services.

Focus groups and in-depth telephone interviews were used by *Bang* (1998) to develop a telephone questionnaire later completed by people 55 years and older about their use of a health information support telephone service (HISTS). Preliminary findings identified an equal number of well-educated male and female callers, who called for information for themselves.

Sivakami and *Kulkarni* (2003) examined whether women from economically, socially, and educationally weaker sections of the society receive adequate maternal health care. Though most women in Tamil Nadu receive antenatal care, many do not get institutional and professional care at delivery. Logic regression analysis shows that in both rural and urban areas only the economic factor, and not the social and educational factors, has a significant net effect on the ability to secure institutional delivery care.

Ajuwon (2006) discussed the limitations of existing media programmes in Nigeria among rural dwellers and recommends alternative ways to meeting the HIV/AIDS education needs of the citizens living in rural communities.

Jodie and *Braunack* (2007) reported the findings of an exploratory study about the information women diagnosed with Polycystic Ovarian Syndrome (PCOS) want to know about their condition and the consequences of this information for future treatment and health outcomes. *Ijirigho* (2010) conducted survey and focus group research on a sample of female undergraduates at the University of Ibadan. Results showed that female undergraduates receive information on contraception regularly through the broadcast media and friends.

Malik (2012) explored the status of women in India. While women in India face many health concerns and has focused on three main aspects: reproductive health, nutritional status, education. Researcher garnered more importance as poor health has repercussions not only for women and her family but to the entire nation.

3.1.10 General Health Issues:

Shanmugam (1981) suggested that information on health needs to include both the concept of health and pertinent ideas and facts about various measures and services available. *Sundaram* (1988) suggested the use of paramedical workers and female health assistant/ health workers supervised by district health officers.

Mukhopadhyay (1988) recommended that traditional channels of communication would help the goal of "Health for All". *Park and Peterson* (1991) recommended use of health care workers who would visit patients more often and give them more opportunities to ask for assistance, when needed, using family members as interpreters.

Mabulay and Subingsubing (1992) recommended for multi sectoral community coalition with community groups, satellite centres, health within communities and to engage the community actively in securing proper child health and awareness through mothers groups.

Rajan (1992) suggested utilizing manpower available at the local level, for designing appropriate training for field workers, in counseling and services to women. It was also suggested to use the service of village leaders (traditional midwives, healers and teachers) to assist health workers in educating village members and to form a village health committee. *Rogers* (1992) suggested for campaign approach for achieving health related life styles.

Sligo and Jameson (2000) reported on perceived barriers among New Zealand Pacific women to the use of cervical screening and proposes solutions for improved access to these services. Respondents strongly favoured sources of information that were mediated through their community groups but smear-takers were preferably non-Pacific in ethnicity.

Uhegbu (2000) studied the existence or otherwise of any interactive information communication networks among women in Imo State. Results show the existence of vibrant interactive networks among women. Social, economic, political and health news and other aspects were found to be the determining information factors. Personal contact and use of liaison or intermediary and institutional frameworks are the means of the interaction.

Cunningham and Ohles (2000) focused on qualitative online resources for women over age 25 that are related to women's health and physical fitness. A major challenge in locating web sources in this area is the need to explore many subject areas.

Harris, Wathen and Fear (2006) highlighted the people living in rural areas may face specific barriers to finding useful health-related information, and their use of information may differ from their urban counterparts. This random-digit dial telephone survey of 253 people (75% female) living in a rural, medically under-serviced area of Ontario, Canada and examine with a larger sample issues related to searching for and using health information. Researcher findings have implications for Canadian government health policy, particularly the use of e-health strategies.

Ugboma (2010) conducted survey of access to reproductive health information amongst rural women in Nigeria with particular reference to Delta State. Findings revealed that reproductive health information (RHI) providers do not exploit appropriate media for dissemination of information in rural communities.

Choi study finds that (2011) older adults are the most frequent and heaviest users of health services in the United States. Older-adult users of general health services were more likely to use HIT than nonusers of general health services, while older-adult users of specialized health services were not different from nonusers of specialized health services in their odds of HIT use. *Shambhunath and Fatima* (2013) suggested to formulate the health related social welfare scheme for the working women in unorganized sector.

3.2 CONCLUSION:

The availability of information and its use is of vital value to women who form half of the world population. Effective communication of information through accessible and available services, helps quality service delivery and improved consumer outcomes and creation of appropriate resource position, development of human resources and institutional resources is an effective way to deliver information to urban women and their families.

The review of literature revealed that a number of studies. Majority of the studies have been conducted to support women with information on health care. On the contrary, the literature from developing countries reveal that studies on information support to women with regard to community information – urban women, urban development, information and communication technology, mass media, general health problems, use of fertilizers and manures, etc. Such studies help in understanding and thereby planning for the development of urban women health information support.

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CHAPTER - 4

HEALTH INFORMATION SUPPORT PROGRAMMES FOR WOMEN

4.1 INTRODUCTION:

Health may not be everything but everything without health is nothing. Thus World Health Organisation's (WHO) constitution proclaims, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. It means the attainment of the highest possible level of health by all. Health is the level of functional or metabolic efficiency of a living organism. In humans, it is the general condition of a person's mind and body, usually meaning to be free from illness, injury or pain. The World Health Organisation (1946) defined health in its broader sense as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is an important area for which women need information support system. Women should know how to take care of their personal health. They must be informed about various health care programmes to keep their children and other family members away from diseases (Sen, 2004).

Access to information would certainly enhance the capability of the individuals to make better use of the resources, take decisions and improve her quality of life. But women suffer from certain inherent problems viz., illiteracy, locational remoteness, male dominated families where she is denied exposure and access to information. Obviously the nation cannot move ahead keeping the major portion of its population in dark. As a result, international organizations, various state and central Governments, NGO's and many corporate sectors are making efforts to provide health information to women (Chatterjee, 2003).

There is a growing body of evidence about what makes people healthy. Each of these factors are important and at the same time interrelated. The following are important determinants of health; income and social status; social support networks; education and literacy; employment/working conditions; social environment; physical environments; personal health practices and coping skills; hygiene; healthy child development; biology and genetic endowment; health services; gender; culture; stress (Vijayapura District Human Development Report, 2014).

4.2 CONCEPT OF HEALTH INFORMATION DISSEMINATION:

Information is the symbolic element used for communicating knowledge, irrespective of their nature, material carriers, form of presentation, etc. It refers to both substance and contents of documents and to physical existence. The term is used to designate both the message and its communication. The term has been widely accepted as the cognitive state of awareness given representation in physical form. This physical representation facilitates the process of knowledge. Information can be found in a range of forms, from the written words (books, periodicals and other forms including microfilm) to audio-visual (TV, radio, movies, etc.) to purely oral communication (such as consultation, sessions, seminars, workshops, symposia, etc.).

Health information serves as a tool, which facilitates more information and better decision to be made, and it helps to identify problem areas and to take timely remedial measures. The term health information has been defined in different ways. In many countries, the term is interpreted to mean health statistical, epidemiological and other health oriented data used in the planning and management of health services by the decision makers and administrators. General public needs information on different areas and aspects of health care.

Health information is disseminated by the professionals for different purposes in different modes. This dissemination may take place in a number of ways. This information cannot reach the end users unless there is a good mechanism for disseminating such information. These agencies provide good number of health information. The purpose for dissemination of the health information varies from one group to other (Yadav, 2004).

4.3 TYPES OF HEALTH INFORMATION/ COMMUNICATION SOURCES:

Communication can be achieved through variety of sources, and the source is often critical to the acceptability of the message. Sources can be grouped into two major categories and the most relevant to healthcare are discussed below.

Traditionally, healthcare consumers have had access to two primary sources of information on healthcare – first one informal and second one formal.

a. **Informal Sources:** Much of the information consumers obtain on healthcare is through informal sources, in the form of family, friends and associates, etc. These ad hoc sources of information are important due to their convenience and their credibility. Even today, healthcare consumers point to individuals in these categories as primary sources for health information. Informal sources may also take the form of social groups, with many consumers obtaining their information concerning health and healthcare in some type of group context.

b. **Formal Sources:** Formal sources usually refer to the printed or published mode of transfer of the information. The formal modes send the information to a wide range of audience. The information once generated in whatever form, should be reached to its users. In doing, so the maximum number of people, availing that message or the quantity of use of that information, is the measure of its quality. Formal communication may take place through books, periodicals, newspaper, audio, visual materials etc.

Sources of Health Information

There are many sources of health information systems for different sect of the society. This section presents the features of the health information sources. The channels highlighted include mass media (e.g., radio, television, newspapers, magazines, comics, teletext, videotext,), human resources (e.g., family members, friends, neighbors, druggists, nurses, librarian, primary healthcare workers, social workers, doctors, health workers, consultants, etc.,), information service systems/institutional resources (e.g., libraries, Government organization, NGO, health institutions, women organization, health and social welfare department, hospitals urban health center, community health centers, primary health centers, mobile health clinic, nature care centers), training and educational programs (e.g., professional preparation, workshops, computer-assisted), internet and e- resources (online databases) and other (e.g., posters). At present health information is disseminated in the form of product and services. It normally supports women in common. They get information from various sources (Saleh and Lasisi, 2011).

These Sources of Information are :

4.3.1 Mass Media:

Mass communication includes electronic and print media. Electronic media includes radio, television and satellite telecommunications, mobile phone. Print media encompasses books, newspapers, magazines, newsletters, and comics. Mass media provides health information to women (Srinivasan, 2002).

4.3.1.1 Radio:

Radio plays a vital role in our modern society. It is faster and the most economic medium available in this electronic age. Radio has established itself as the best means of communication. It provides a speed-up of information. The radio fulfills three major objectives, viz. information, education and entertainment.

The AIR programmes include discussions, music, literary programmes, children programmes, and village broadcastings, general educational broadcasts for school children, women's programme, farmer's programmes, news, radio news-reel and special broadcasts for students. Besides, it broadcasts programmes for labourers, army, sports commentaries and special programmes on the days of national importance such as Independence Day, Republic day, etc.

Radio has been very effective for disseminating information to all types of audience. Radio if linked to internet, may become more effective. (www7.itu.int/ itufd97.html). Through radio we can communicate with thousands of people. There are a number of radio stations in the country.

The regional channels, broadcast largely on the medium wave frequency, follow a composite programme pattern comprising of music - classical, light, folk and film, news and current affairs, radio plays, features, farm and home programmes, programmes on health & family welfare and programmes for woman, children, etc.
AIR Channels on different modes of transmission in Karnataka:

AM MODE:

1) Bengaluru 2) Bhadravati 3) Dharwad 4) Kalaburagi 5) Mangaluru 6) Mysuru

FM MODE:

1) Bengaluru 2) Dharwad 3) Kalaburagi 4) Mysuru 5) Chitradurga 6) Hassan 7) Hosapete 8) Raichur 9) Madikeri 10) Karwar 11) Vijayapura 12) Bellary 13) Mangaluru

(i) AIR Programmes:

Today, the external services division (ESD) of all India radio broadcasts daily 57 transmissions with almost 72 hours covering over 108 countries in 27 languages, out of which 15 are foreign and 12 Indian. The Indian languages are Bengali, Gujarati, Hindi, Kannada, Malayalam, Nepali, Punjabi, Saraiki, Sindhi, Tamil, Telugu and Urdu.

a. Health & Family Welfare Programmes:

AIR, with its vast network of about 225 radio stations, broadcast programmes on health and family welfare. All AIR stations broadcast family welfare programmes in the regional languages. Health programmes are the regular broadcasts of all India radio. The subjects covered in the regular broadcasts of health programmes are ; rise in marriage age, delay the first child, space between two children, terminal methods, maternal care, child survival, women empowerment, promotion of inter-spouse communication/male responsibility, neutralizing male preference syndrome, medical terminal of pregnancy, promotion of institutional legal provisions, management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), pre-natal diagnostic techniques (regulation and prevention of misuse) Act 1994, AIDS, drug abuse, breast feeding, child right, child labour, girl child, disability, T. B., Leprosy and reproductive child health, etc. All national international days on health and family welfare issues are observed by all AIR stations by mounting special informative programmes.

The ministry of health & family welfare, Government of India has signed a MoU with prasar bharati for broadcast of a half an hour health programme for five days a week over 29 stations of all India radio. The programme has been launched on 7th of April, 2012 on the occasion of World health day. The main aim of the campaign is to inform and educate the listeners on health issues through the terrestrial reach of prasar bharati.

b. Women Programmes:

All Stations broadcast programmes for rural women as well as urban women at the timing convenient for listening by the respective target groups. The programme directed to women listeners cover subjects related to socio-economic development of women, health and family welfare, food and nutrition, scientific home management, women entrepreneurship, education, including adult education, gender issues, etc. These programmes also aim at creating wide social awareness about rights and privileges of women through the propagation of legal literacy.

All India Radio strives, through its programmes, to seek to raise the social consciousness of the country in regard to attitude towards women. Different traditional folk forms are used to communicate specially with the rural women audience. Besides the issue of women forming the main part of the women's programmes, the problems in general faced by women and the need for change in social attitude towards women also forms an integral part of the general broadcasts. Formats of the programmes like talks, plays, short stories, features, discussions, etc. based on themes such as crime against women, preference for a girl child, evils of dowry system, gender inequity and female infanticide, improvement of the status of women are constantly being broadcast in the programmes meant for the general programmes. Special programmes as well as general audience programmes are being broadcast focusing on the issue to change social attitudes and behavioural practices towards women. Guidelines are issued to all AIR programme heads from time to time to plan and produce programmes for women with the aim of their empowerment and to ensure that women issues are projected as social issues rather than as issues concerning women only.

The objective of the women's empowerment programme was to create large scale awareness of women's right and to focus on issues and interventions, which can bring positive impact on their lives. The continuously declining sex ratio manifests a clear gender bias against female child. This is also exhibited in their poor health and literacy pointers. Low nutritional level of female child and marriage of girls at an early age are leading to prevalence of very high levels of anaemia among adolescent girls / mothers and a very high number of maternal deaths. Their participation in the economy continues to be still at low level. Violence against women is another very

major area of concern. In this context, the yearlong activities on status of women and their rights, and launching of programmes for interventions, required to bring about a change, which would build up an environment conducive to developing self-confidence and assertiveness among women and girls (Prasar bharati, 2007), scribd and allindiaradio.gov.in).

All India Radio broadcasts a number of programmes in different formats for the welfare of girl child. Programmes of the family welfare section of the stations generally aim at creating social awareness on the issues relating to female foctus, gender discrimination, awareness about the rights and privileges of women through the propagation of legal literacy. Different traditional folk forms were also used to communicate with the rural audience. “Beti Bachao Beti Padhao” programme was launched by the prime minister in 2015. After the launch of programme, the director general, All India Radio has issued instruction to all stations to give special attention while planning their programmes on the popularization of the ‘Beti Bachao Beti Padhao”. The same campaign continues in 2017.

The 2017 theme for international women’s day is, “women in the changing world of work: Planet 50-50 by 2030”. Programmes were broadcasted in different formats on the theme as talks, discussions, interviews etc with women achievers from urban as well as rural areas from different walks of life, highlighting their achievements. International women’s week of this year was also observed with the view of empowering women in the society. Apart from this, on the basis of references received from different ministries regarding problems confronting women, programme heads of all AIR stations were advised to focus in the women’s programmes related to sexual crimes against women, indecent portrayal of women in media, breast cancer awareness month and menstrual hygiene. AIR also contributed in collaboration with UNICEF in their programmes related to women and children such as routine immunization, gender violence, encourage breast feeding (MAA programmes), etc. (www.prasarbharati.gov.in).

c. Health Programmes:

Health programmes are part of regular broadcasts of All India Radio. Almost every AIR station broadcasts health awareness programmes on regular basis. These programmes are planned and broadcast as per the health requirement of the concerned area, potential out-break of seasonal diseases and as per the instructions / advice of ministry and the directorate general of all India radio. All the health related issues as awareness about disease, their causes and prevention, information about available treatment, awareness about immunization information, government facilities for the treatment of different diseases and heath related government schemes are taken up under the programme.

Other subjects covered in regular broadcast of health programmes include topics like right age of marriage, delay the first child, space between two children, terminal methods, maternal care, child survival, promotion of inter-spouse communication / male responsibility, neutralizing male preference syndrome, medical termination of pregnancy, promotion of institutional legal provisions, management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), pre-natal diagnostic techniques (regulations and prevention of misuse) act- 1994, breast feeding, disability, T.B., leprosy and reproductive child health etc.

Nutrition has also been focus of many programmes of AIR broadcasts. National nutrition day was given wide coverage and information disseminated about the importance of nutrition during the formative years of children and lactating women.

Breast cancer awareness month was also publicized to generate awareness about the causes, symptoms, prevention and cure in women of all age groups. The breast cancer awareness month, marked in countries across the world every October, helps to increase attention and support for awareness, early detection and treatment as well as palliative care of this disease.

In some of our special audience programmes like rural/women/youth & health, AIR registered audience groups. These groups contributed towards spreading of general awareness on the health related subjects. Under women empowerment major thrust has been on “Swachh Shakti Saptah” in which Government of India stressed on

linking women with sanitation and hygiene in society. Protection against sexual crimes and other atrocities has always been a major focus and AIR's role has been pivotal in improving women's condition in society and improving image of women in media.

NSD, AIR gave wide coverage to various social, economic and developmental schemes/programmes launched by the government from time to time such as financial inclusion, digital India, cleanliness drives, make in India, start up, bhim app, pradhan mantri awas yojana, pradhan mantri ujjawala yojana, rights of persons with disabilities, Accessible India campaign etc. through news bulletins as well as talks and current affairs programmes. The news items on government schemes were also posted by social media unit on twitter and facebook pages on regular basis. Regional news units of AIR also gave wide coverage to the Government schemes in their respective regional bulletins and mounted programmes on the related subjects (www.prasarbharati.gov.in).

d. Present Radio Programmes:

All India Radio is broadcasting many useful programmes for women. They mainly deal with women's problems like health, education, agriculture, social evils like dowry, superstitions, maintenance of houses and other matters related to women. Women take the advantages of radio programmes at their leisure hours. All India Radio is broadcasting programmes like radio doctor, mahila ranga and graha laxmi, keeping women in mind. Women take necessary and useful information from such programmes and take benefits from them.

Radio stations broadcast programmes on special groups like women, children, farmers, health and youth and so on, which are discussed below.

(ii) Vijayapura Station:

Women's programmes: AIR Vijayapura broadcast various women related programmes. Contents of this programmes are on cooking; new recipes, health and hygiene, horticulture, sericulture and agriculture, sewing, beauty, family planning and about of their rights. Besides these programmes there would be certain talks, discussions, interviews with highly qualified veteran women who contributed much

contribution to the society. AIR is also broadcasting about important festivals like dasara, deepavali, ramzan and national festivals like Independence day, Republic day, etc.

Health Programmes: AIR Vijayapura broadcast various health programmes. Health programmes like 'Radio Doctor' (8.30am) a useful programme on health and hygiene is broadcasted every day (except Friday) at 8.30am. The programme provides information be on women's health pregnancy, child care of good health, creating awareness of deadly diseases like HIV, H1 N1, Women health issues and dangerous diseases.

Table 4.1: Vijayapura AIR present programmes
(Monday to Sunday during February, 2016)

Monday	6.45am Udyoga Varthe, 6.50 Janapada Sangeetha, 7.15 Baduku Jataka Bandi, 7.45 Chitrageetegalu,/ 8.30 Radio Doctor, 8.35 Rastriya Sangeetha Karyakramagalu, 9.05 Mishra Geetegalu, 9.30 Keli Haadu Keli,10.00 Mumbai Kendrada Prasaradalli, 12.30pm Navu Neevu (Phone in Programme), 1.20 Nimma Maatu Namma Hadu, 1.45 Hosa Dishe, 2.35 Bandani, 3.05 Sakhi Saheli, 4.00 Mishra Madurya, 6.05 Staliya Samachar, 6.15 Chitra Geetegalu, 6.30 Zilla Vartha Patra, 6.50 Kissan Vani, 7.45 Chitra Geetegalu, 8.00 Pragathi Phala, 8.15 Yuva Vani, 8.30 Pushpa Haara, 9.16 Savi Nenapu, 9.30 Nataka, 10.00 Rashtriya Sangeetha, 10.30 Aapki Farmayish
Tuesday	6.45am Swalpa Keliri, 6.50 Janapada Sangeetha Karyakrama, 7.16 Bhava Geetegalu, 7.45 Chitrageetegalu, 8.30 Radio Doctor, 8.35 Hindustani Rashtriya Sangeetha Karyakrama, 9.05 Mishra Geetegalu, 9.30 Keli Haadu, 10.00 Mumbai Kendrada Sahaprasaradalli, 11.30 Keli Kali Karyakrama, 12.00pm Chukki Chinna, 12.30 Nataka, 1.00 Bhava Geetegalu, 1.20 Nimma Maatu Namma Hadu, 2.30 Chinnara Chukki, 3.05 Sakhi Saheli, 4 .00 Mishra Madurya, 6.05 Staliya Samachar, 6.15 Chitra Geetegalu, 6.25 Nilayada Karyakramagala Parichaya, 6.30 Avalokana, 6.50 Kissan Vani Karyakrama, 7.45 Chitra Geetegalu, 8.00 Yuva Vani, 8.30 Pushpa Hara, 9.16 Savi Nenapu, 9.30 Prayojita Karyakrama, 10.30 Kridalokha
Wednesday	6.45am Swalpa Keliri, 6.50 Janapada Sangeetha Karyakrama, 7.15 Sarva Shikshana Sanchalana, 7.45 Chitra Geetegalu, 8.30 Radio Doctor, 8.35 Anna Bhagya, 9.05 Mishra Geetegalu, 9.30 Keli Hadu Keli, 10.00 Mumbai Kendrada Sahaprasara, 11.30 Keli Kali Karyakrama, 12.00pm Chukki Chinna, 12.30 Mana Mechida Haadu, 1.20 Nimma Matu Namma Haadu, 2.35 Chinnara Chukki, 3.05 Sakhi

	Saheli, 4.00 Mishra Madhurya, 6.05 Sthaliya Samachar, 6.15 Chitra Geetegalu, 6.30 Rasa Varthe, 7.00 Phone in Karyakrama, 7.45 Chitra Geetegalu, 8.00 Prayojitha Karyakrama, 9.16 Savi Nenapu, 9.30 Shikshana Samvada, 10.30 Aapki Farmayish
Thursday	6.45am Udyoga Varthe, 6.50 Janapada Sangeetha, 7.15 Prayojitha Karyakrama, 7.45 Chitra Geetegalu, 8.35 Savayava Krishi Kuritu mahiti, 9.05 Mishra Geetegalu, 9.30 Keli Haadu Keli, 10.00 Mumbai Vivida Bharati Karyakrama, 11.30 Keli Kali, 12.00pm Chukki Chinna, 12.30 Akka Tangi Antyakshari, 1.20 Nimma Maatu Namma Hadu, 2.35 Chinnara Chukki, 3.05 Sakhi Saheli, 4.00 Mishra Madhurya, 6.05 Staliya Samachar, 6.15 Chitra Geetegalu, 6.25 Karyakramagala Parichaya, 6.30 Zilla Vartha Patra, 6.50 Kissan Vani, 7.45 Chitra Geetegalu, 8.00 Hosa Hejje, 8.30 Pushpa Haara, 9.16 Savi Nenapu, 9.30 Vignyana Bharathi, 10.00 Rashtriya Sangeetha,10.30 Aapki Farmayish
Friday	6.45am Gandhi Smrithi, 7.15 Amma Nanage e Maduve Beda, 7.45 Chitra Geetegalu, 8.30 Radio Doctor, 8.35 Shastriya Sangeetha, 9.05 Mishra Geetegalu, 9.30 Keli Haadu Keli, 10.00 Mumbai Kendrada Prasaradall, 11.30 Keli Kali, 12.00pm Chukki Chinna, 12.30 Jeevana jopana, 1.00 Bhava Geethegalu, 1.20 Nimma Maatu Namma Hadu,2.35 Chinnara Chukki, 3.05 Mumbai vivida bharati Karyakramagalu, 4.00 Mishra Madhurya, 6.05 Sthaliya Samachar, 6.15 Chitra Geetegalu, 6.25 Karyakramagala Parichaya, 6.30 Avalokan, 6.55 Kissan Vani, 7.45 Chitra Geetegalu, 8.00 Yuva Vani, 8.30 Pushpa Haara, 9.16 Savi Nenapu, 9.30 Mumbai vivida bharati Karyakramagalu, 10.00 Hindustani Shastriya Sangeetha,10.30 Aapki Farmayish
Saturday	6.45am Swalpa Keliri, 6.50 Janapada Sangeetha, 7.00 Karyakramagala Mukyamshagalu, 7.15 Kaanunu Arihu Mudisuva Karyakrama, 7.30 Seva Mahithi, 7.45 Chitra Geetegalu, 8.30 Radio Doctor, 8.35 Hindustani Shastriya Sangeetha, 9.05 Mishra Geetegalu, 9.30 Keli Hadu Keli, 10.00 Mumbai Vivida Bharathi Kendra, 12.30pm Baduku jataka bandi, 1.00 Ruchi Abhiruchi Karyakrama, 1.20 Nimma Matu Namma Haadu, 2.35 Baalu Belaku, 3.05 Mumbai vivida bharati Karyakramagalu, 4.00 Mishra Madurya, 6.05 Staliya Samachar, 6.15 Chitra Geetegalu, 6.25 Nilayadinda Prasaravaguva Karyakramagala vivara, 6.30 Rasa Varthe, 6.35 Seva Mahithi, 6.51 Janapada Nataka, 7.45 Samachara Darshana, 8.00 Yuva Vani, 8.30 Pushpa Haara, 9.16 Savi Nenapu, 9.30 Rashtriya Sangeetha Karyakrama
Sunday	6.45am Swalpa Keliri, 6.50 Janapada Sangeetha,7.00 Prakatanegalu, 7.16 Savi Savi Nenapu, 7.30 Prakatanegalu, 7.45 Chitra Geetegalu, 8.30 Radio Doctor, 8.35 Chitra Sangama, 9.05 Ravivarada Vishesha Karyakramagalu, 10.00 Mumbai Vividha Bharathi Kendrada

	Karyakramagalu, 12.30pm Makkala Loka, 1.00 Bhava Geetegalu, 1.20 Hrudaya Geethe, 2.35 Chalana Chitra Dwani Vahini, 4.00 Mishra Madurya, 6.05 Staliya Samachar, 6.15 Sambalisutta Sagona Bhala Patradalli, 6.25 Karyakramagala Vivara, 6.30 Seva Mahithi, 6.50 Kissan Vani, 7.45 Mane Maneyalli, 8.00 Ravivarada Rasaprashne, 8.30 Kendra Sarakarada Vividha Yojanegala Kuritu, 9.16 Savi Nenapu, 9.30 Ravivara Siri Akhila Bharat Sangeetha Sabha, Delhi Kendrada Prasaradalli

4.3.1.2 Television:

Television (TV) came to India in 1950s on experimental basis with the transmission around Delhi only. Over a period of time it got other parts of the country. It is estimated that about 85 percent people in India have access to television, and 41 per cent of television viewers watch programmes on cable TV network along with national channel (www.allindiaradio.gov.in).

Nowadays Television (TV) is giving lot of importance in empowering women by telecasting good programmes to empower them in the areas of social, cultural, economical, educational, legal, decision making, health, technological, equal rights, freedom of expression, gender sensitization, etc (Hiremath, 2009).

a) Present Television Programmes:

Television programmes are very useful and powerful media. Media educates men and women in many ways. They telecast programmes on animal husbandry, agriculture, family welfare, health and hygiene programmes for youths and women. Doordarshan many paid channels are also telecasted viz.,Colours Kannada, Zee TV, Kasturi, TV9, Suvarna, Samaya, Public TV, Jansri TV and others. The above channels are telecasting not only entertainment and news but also useful programmes for women. There are so many educating programmes for women i.e. health care, agriculture, cooking recipes, sports and other useful programmes (Manorama year book, 2017).

Chandana: Is a familiar TV channel. Chandana is broadcasting many useful programmes for women related to their health. Health programmes like 'TV Doctor' at 12.00pm on Wednesday. 'Health' programme at 9.00am on Monday, 'Hello Sakhi' at 12.00pm on Monday, 'Arogya Bharatha' at 7.30pm from Monday to Friday, 'Spon-RPT Health Programme' at 8.00pm on Wednesday and Saturday 'Beauty Tips' at 3.00pm on Saturday and Sunday, 'Yoga/Aerobics' at 6.45am on Sunday and 'Women Programme' at 11.30am on Sunday. It is very useful programme for women.

TV9 Kannada: TV9 is very familiar and useful channel. It is broadcasting useful programmes for ladies. TV9 is broadcasting a programme that is called 'Ladies Club' on every Sunday at 1.30pm. It is half an hour's (30 minutes) programme. This programme highlights Ladies problems and other selected information. TV9 is broadcasting so many useful programmes for women including of their health and hygiene and 'Yoga Yoga' programme telecasted at 6.45am from Tuesday to Saturday. Everyone likes to watch programmes telecasted on this channel but TV9 has allotted less time for women related programmes.

Kalki Kannada: Kalki Kannada TV is a general entertainment television channel. 'Surabhi' programme is not just a show but is a platform for voicing out all women related issues such as their health, beauty, fitness, parental issues, child health etc. In this show we have experts answering queries pertaining to women's personal problems and questions. 'Surabhi' telecast at 1.30pm to 2.00pm from Monday to Friday. 'Namaste Karunadu' programme telecast at 7.00am from Monday to Friday. It is a morning show divided into 4 parts that include : 'Mankuthimmana Kagga', also popularly known as the Bhagwatha Geetha of Karnataka, 'Mudra Yoga', a session with a Mudra Expert teaching various Mudras that can help us stay healthy, 'Angaili Owshadhi', a session where natural tips are given to help us maintain good health.

Udaya TV: Udaya TV is a regional Kannada language channel. It is also the first Kannada satellite channel in India. 'Siri' prgramme telecast at 8.30am to 9.00am on Saturday and Sunday and 1.30pm from Tuesday to Thursday. This programme covers women information and tips on their physical wellness while experts demonstrate various hobby ideas. 'Nati Vaidya' at 7.35am on Tuesday, Wednesday and Thursday.

Public TV: Public TV is a Kannada Language news channel. This channel is broadcasting various programmes in general. This channel also telecast health related programmes like 'Nithya Sanjeevini' and 'Yoga Phala'.'Nithya Sanjeevini' programme telecasted on Monday to Sunday at 8.55am, 12.25pm and 2.25pm. 'Yoga Phala' programme for yoga exercises that will help to stay fit and maintain good health.

Kasthuri TV: Kasthuri channel is the most viewed channel. This channel telecast various health related programme i.e. 'Lifeline Live' programme telecast on Tuesday at 1.30pm, 'Homeo care live' programme telecast from Monday to Sunday at 11.30am, 'Namma Homeopathy live' programme telecast on Monday, Wednesday, Friday and Saturday at 1.30pm and on Sunday and Saturday at 5.00pm.

Kasthuri Newz 24: Kasthuri news channel telecast health related programmes that is 'Yoga Mantra' at 7.15am, 'Ladies time' at 12.15pm and 'Doctors Paid' at 4.30pm from Monday to Sunday.

Janasri TV: Janasri TV channel is telecasted in Kannada language. This channel telecasts various programmes for people. Janasri TV channel is broadcasting health related programmes. Health programmes like 'Health center' broadcasted daily except Sunday at 5.00pm. Through this programme, Janasri TV reminds that health is wealth. But strangely enough health is related with the environment too and the viruses and the bacteria that affect us are mostly seasonal. One needs to keep oneself updated about what is happening around and the precautions that needs to be taken. The doctors and the specialists discuss about the prevailing diseases that are currently around. This is also an interactive and unique kind of a Kannada TV program show where the audiences can also ask questions and get remedies from the specialists. The specialist hospitals and health centres and their contact addresses and details are also displayed so that one can contact in case of emergencies. 'Doctors Nature Clinic' programme broadcast on Monday, Wednesday and Friday at 9.00am, 'Clinic' programme is broadcasted daily except Tuesday at 1.30pm.

Samaya: Samaya is one of the familiar TV channel. Samaya channel broadcasts programmes for women. Women programme like 'Ladies voice' programme telecast at 1.30pm and 'Stri Samrajya' at 12.30pm from Monday to Sunday.

Suvarna News: One more familiar TV channel is Suvarna. Suvarna channel also broadcasts many programmes. ‘Dear Doctor’ (health tips) programme broadcasted every day at 1.30pm to 2.30pm. In this programme health experts from various medical fields share healthy tips for a nutritious lifestyle.

News BTV: BTV News professional regional news channel in Telagu which is set up in Karnataka and being entirely run by ethics less journalists. This channel telecast various programmes. ‘B Healthy’ programme is one of the health related programme telecasted daily at 2.30pm and ‘Naari Gallery’ at 3.00pm. ‘Workout/Aerobics/ Yogasutra’ programme broadcasted on Thursday and Friday at 6.45am.

ETV News Kannada: ETV is a Kannada language news channel. This channel is broadcasting various programmes in that ‘Hello Doctor’ is one of the helath related programme. This programme telecast on Monday, Tuesday, Thursday, Saturday, Friday and Sunday at 2.30pm.

Raj News 24x7: Raj group of channels is one of the leading and competitive channels in India. It is one of the first and most successful channels in South region. Raj’s diverse offerings in news, music and entertainment capability in delivering high quality programming to audiences in India and to the South Asian community across the region. Raj delivers the channels in multilingual Indian languages. Raj channel starts with Tamil entertainment as Raj TV and expanded with movies, news and musics. In the South region Raj is the first channel starts the other Indian languages in Hindi, Telugu, Kannada, Malayalam as Entertainment, Movies, NEWS and Musics. Raj news broadcast various health programmes i.e.‘Herbal Medicine’ programme broadcast on Monday, Wednesday, Thursday, Friday, Saturday and Sunday at 10.30pm and 11.00pm and this programme telecast on Sunday at 5.00pm and 5.30pm. ‘Naturopathy Medicine’ programme telecast on Tuesday at 10.30pm and 11.00pm.

Sarala Jeevana: Saral Jeevana is 1st info-entertainment channel in Kannada, owned by CG Parivar Global Vision Private Limited launched on 19th Feb, 2016 by Dr. Chandrashekhar Guruji. Saral Jeevan telecasts news and non-fiction programming with a focus on mythology, history, health, travel and insights from Indian heritage & culture. This channel telecast health related programmes that is ‘Hello Doctor’ and

‘Mane Maddu’. ‘Hello Doctor’ programme telecast on everyday at 4.00pm and Wednesday at 4.30pm. Another famous health related programme i.e ‘Mane Maddu’ telecast on Sunday at 11.30am.

Zee TV: It is a useful channel for women. Another most viewed channel is Zee Kannada. Zee Kannada channel also broadcasts so many programmes. Zee TV broadcast many health programmes. In this ‘Yoga for you’ and ‘Yogic Helaing by Swami Ramdev’ programme provide programme for *yoga* exercises that will help to stay fit and maintain good health. Baba Ramdev talks about the importance and significance of yoga and shares Ayurvedic remedies for treating various illnesses.

Aastha: Aastha TV is a spiritual TV network in India. Established in 2000, it is owned by Aastha Broadcasting Network Ltd., This channel telecast various health prograrmmes that is ‘Yog Shivir’, ‘Ayurved Evam Jivan Darshan’, ‘Dhyan Yog’, ‘Khel Khel Me Yog’, ‘Seva Ganga’. Baba Ramdev, a yoga guru demonstrates various yoga moves that help to tackle day-to-day ailments. This program features an ancient Indian medicinal system of Ayurveda. Acharaji recommends lifestyle and eating habits that can be practiced for a healthy and blissful living. Take a look at a discourse on the essence of meditation, including its common difficulties and milestones. Yoga guru Swami Ramdevji and Acharya Balkrishnaji explain to the children and adults the benefits of performing yogic exercises in a simple manner. Narayan seva sansthan is the largest and only organization that offers free food and medical services to the poor regardless of their caste, religion or ethnicity.

4.3.1.3 Newspapers and Magazines:

Newspapers, magazines and books are a good means of mass-communication. This is a print medium which travels far and wide. The newspapers have a very wide circulation and every literate person tries to go through them. (www.libraryjunction.net).

In this modern age newspapers play a very important role in promoting commerce, trade and business. Big corporate and industrial houses promote their products by giving spacious advertisements in newspapers. Classified advertisements, important public announcements and public notices also constitute the important content and material of newspapers (www. indiastudychannel.com).

Newspaper have been the most conventional and popular medium of conveying local, regional, national and international news to the readers. Newspaper serves us the latest happenings in different parts of the world through a network of correspondents and news agencies (http://malabarroute.blogspot.in). The national dailies employ their correspondents and reporters in all the major cities of the world. The major newspapers like Kannada Prabha, Prajavani, Samyuktha Karnataka, Vijaya Karnataka, Udayavani, Deccan Herald, The Hindu, Times of India, Indian Express would, shape and influence the views, opinions and attitudes of thousands of readers throughout the state.

The newspapers are available in English, Kannada, Hindi and many local languages. They are the least costly of the print media and their contents cover day to day happenings which touch on people's lives includes security, transport, political, education, social events, etc.

a) Newspapers in Kannada:

Kannada Prabha: Kannada Prabha is very famous Kannada news portal. It covers news from every district of Karnataka. It considers itself as a most famous Kannada newspaper. Leading newspaper in Karnataka covering latest news on politics, sports news, cinema, gallery, actress, movies, astrology, cricket, hockey, tennis, and other sports news, state, advertisements, International news, etc. Kannada Prabha newspapers supplements are Baitu Coffee, Property Prapancha, Kushi. Kannada Prabha offers a variety columns everyday on politics, science, consumer notes, technology, law, etc.

Vijaya Karnataka: Vijaya Karnataka is a Kannada daily newspaper in Karnataka. It brings the latest news from Karnataka, India. It is the major daily newspaper based in Bangalore. 'LavalVK' supplement comes everyday with different aspect. This supplement is related to women aspect, health, education, film, etc. Some of the prominent supplements of Vijaya Katnataka include LavalVK (Women), LavalVK (Employment), LavalVK (Health), LavalVK (Education and General), Cine LavalVK (Film, TV and Entertainment), Saturday supplement is BhodiVruksha and the Sunday supplement is Saptahika LavalVK.

Udayavani: It is one of the leading newspapers in Kannada language. Newspaper published from Bangalore, Manipal and Mumbai. Udayavani provides supplements like Saptahika Sampada (Sunday), Isiri (Monday), Josh (Tuesday), Avalu (Wednesday), Bahumukhi (Thursday), Cinilavalavike (Friday), Chinnari (Saturday). Avalu', in two pages which comes on Wednesday. Saptahika Sampada' is regular health counseling column. Sometimes home remedies are given in this page and any research based information that deals with women is also given but not regularly.

Samyukta Karnataka: Samyukta Karnataka is a Kannada language newspaper. It is published from Hubli city of Karnataka. It brings all the latest local breaking news. It is oldest daily newspaper based in Hubli, Karnataka. The newspaper founded by Loka Shikshana Trust. Samyukta Karnataka supplement are SKcity (Narisingari) (Monday), Navayuva (Tuesday), SKcity (Wednesday), Chitrasourabha (Friday), Kindarajogi (Saturday), Sapthahika Sourabha (Sunday). Samyukta Karnataka women related supplements are SK City 'Narisingari' which comes on Monday. Only one page is devoted for women related topics and one page will be for culture, research, health and fashion subjects. Home remedies are also given but regularly beauty tips of celebrities are given here too.

Prajavani: It is a publication from Deccan Herald. It is one of the most famous newspapers in Karnataka. It has a lot of sections to offer i.e. cinema, education, agriculture, women, music, etc. Leading daily newspaper published from Bangalore. Prajavani is one of the largest circulation Kannada language newspapers in the state of Karnataka. 'Bhumika' a supplement comes on Saturday, covers variety of subjects that deal with women's problems, and adoptable concepts are touched especially in beauty columns, health problems and also recipes. Bhumika carries successful women's tips in a more attractive way. It can be celebrity touch to specialist opinion.

Vijayavani: Vijayavani is a Kannada language number one Kannada daily newspaper distributed in the Indian state of Karnataka. Vijayavani provides supplements like Vittavani (Monday), Lalitha (Tuesday), Masth (Wednesday), Sanskrithi (Thursday), Cinevani (Friday), Putani (Saturday), Vijayavihara (Sunday). Lalitha supplement comes on Tuesday, it covers variety of subjects of women aspects.

b) Newspapers in English:

Deccan Herald: Deccan Herald newspaper is published from Karnataka. It features all local, business and world news in depth. Leading English language daily newspaper (www.deccanherald.com). Indian Express: Indian Express is a daily English language newspaper from India, which covers all the latest news from India. It covers news about business, sports, film, religion, state, international news education, health, fashion, etc. The Hindu: The Hindu is a newspaper giving good competition to Times of India and Hindustan Times. Its coverage includes topics of regional news, Karnataka news, editorial, international news, tenders/notifications, business, market, sports, education, etc. The Times of India: The Times of India is a number one English newspaper of India. It has global reach around world. It has a very good online portal. It covers all the latest news like times region, times Bangalore, times nation, times global, the times of ideas, times business, education times, times sport, etc.

c) Health Magazines in English Language:

Women related magazines are available in Kannada, English, Hindi, Telugu, Tamil, Malayalam and other many languages and deal with Arogya, Arogya vani, Arogya Sandesh, Health and Nutrition, Women's Health. Arogyavani, Health, Prevention, Fitness, Yoga, Swasthya Aur Jeevan, Health Plus, Chandrodaya, HEAL, Yog Sandesh, Health Vision, etc., for knowledge improvement of women. These are specially designed to provide the information about the women interest. These magazines shows close look at women, how to handle career and family life. We can find more concepts related to beauty, style, fashion, career, lifestyle, health and diet, etc. Health related magazines and some general magazines which cover women health related issues are described below.

Health and Nutrition: India's consumer bible for healthcare, Health & Nutrition is a true encyclopaedia of groundbreaking medical research, symptoms, diagnosis, prevention, wellbeing & workout mantras. Stay fit and healthy with a regular dose of H&N! (www.magzter.com).

Prevention: Prevention magazine was started off in 1950 and is a lifestyle cum health magazine. The magazine has over a million readers per month which is a mammoth achievement in itself considering the choices that are offered in the health and fitness niche. Although its name suggests that it would offer a lot on disease prevention, it caters to health and wellness and anything that has to do with it. Popular health magazine featuring expert information about recent health news, diseases and conditions, weight-loss, fitness, exercise, recipes and natural healing.

Health Plus: Health Plus magazine includes plenty of features on health, real life, makeovers, beauty and celebrity interviews related to health. The content is upbeat and informative, and is clearly aimed at providing various useful health tips for the readers. It is available in Hindi and English and is a wonder treasure of medicines approved by renowned doctors. The readers can get complete and reliable treatments for all types of diseases. The magazine also encourages its readers to send the queries to the editor so that the remedies for the diseases can be published in the magazine (www.bookstok.com).

Women's Health: Tips and advice for women, with focus on health, fitness, weight loss, nutrition, sex and relationships, emotional well-being, beauty and style.

Fitness: Fitness magazine is a women's health magazine that puts out ten editions per annum. It was flagged off in 1992 and has since then become one of the most popular magazines in the world. The magazine has attained a peak of growth and bagged significant number of awards for its many commendable columns which provide a lot of instructional advice for women. Besides that the magazine also caters to events to promote health among the general public.

Health Café: HealthCafe' publish magazines, one of the most exciting aspects of magazine is that it genuinely belongs to the reader. Every issue of magazine comes packed with information on health, wellness, fitness and lot more (www.healthcafe.in/).

Heal: Heal is a free magazine for cancer survivors focused on living well after cancer. It is a part of the CURE media family. Heal features cancer-related research, education, and contributions from survivors who share experiences from their cancer journeys.

Health: Health magazine has been in business since 1981 and has established itself as one of the best and the most accessible of all health magazines on offer anywhere in the world. The topics that are often covered range from diet tips, fashion tips, skincare, stress relief and pretty much every health and fitness topic that the editors find good enough to go through its pages. With a readership of more than a million every year and monthly editions it is one of the best health magazines that you can hope to encounter. Magazine covers well-being, fitness, nutrition, and beauty.

Health Vision: It's English monthly health magazine known as 'Ayur Pharma HEALTH MAG' to celebrate people and companies who have made a difference in health Sector. Since July 2014 it is named as "HEALTH VISION". Both the magazine includes diverse column featuring general health, beauty, nutrition, child care, yoga, food, pregnancy, women health, fitness, health focus, health news, eye care, well being, home care tips, personality development, pet therapy and so on. This magazine is a complete family magazine on health, pharma and ayurveda. It covers articles and news on Health sector. It provides a platform to all health care professionals and research communities to share their findings, ideas and activities (http://healthvision.in/about-us/).

d) Health Magazines in Kannada Language:

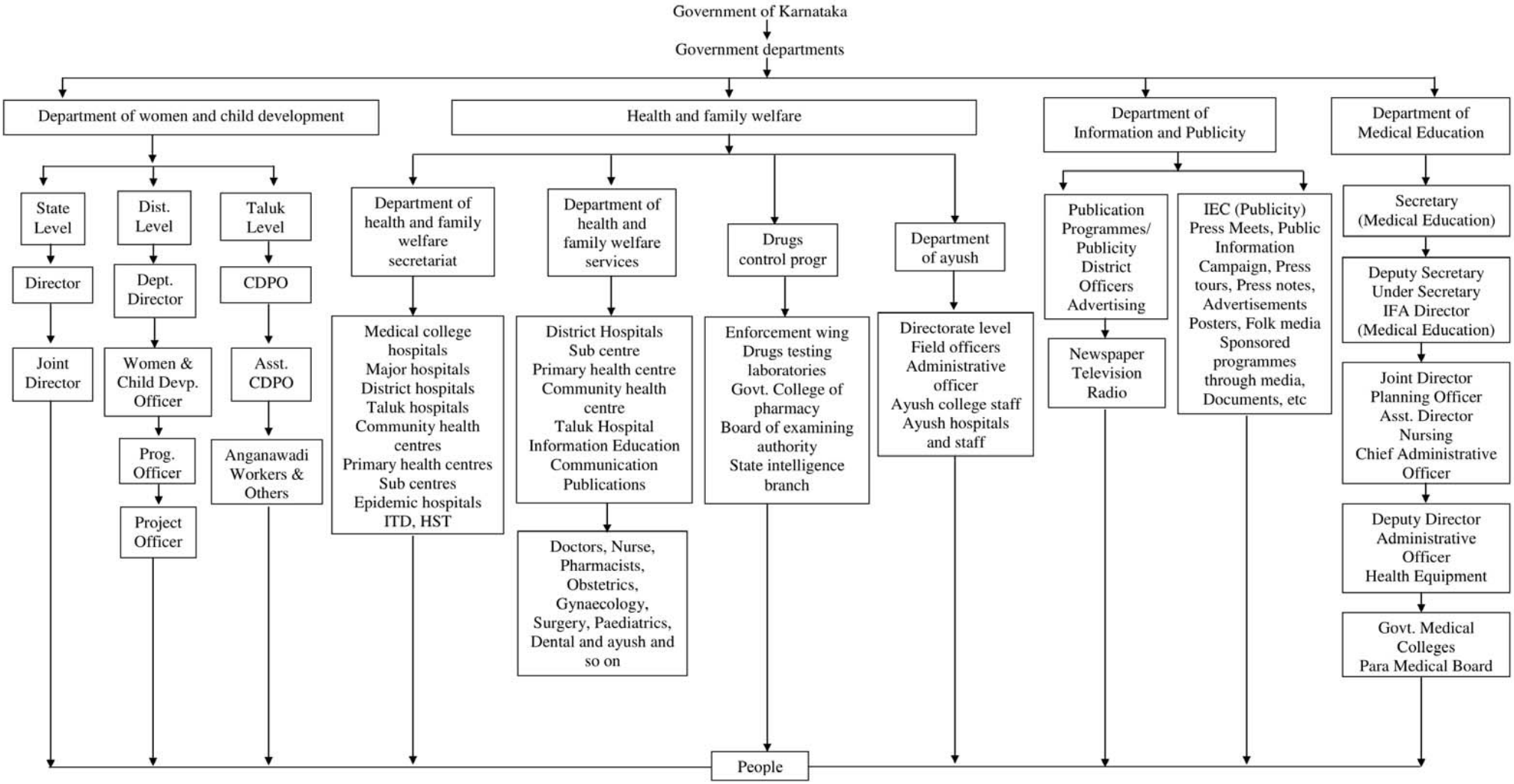
Vydyaloka: Vydyaloka Kannada Health magazine highlights on beauty, nutrition, health, fitness, life style, fitness, diet, personality development, life style, ayurveda, yoga, etc,. Since 2003 media icon, through its Kannada health magazine "Vaidyaloka" successively celebrates various projects, ideas, campaigns and activities, making sustainable change in the health world. This magazine published in Kannada language and it serves as a health catalyst to the kannadigas. Sanjeevini, Arogyavani, Yoga, Arogya Sandesh, Yog Sandesh, Swasthya Aur Jeevan are the popular health magazine featuring expert information about recent health news, diseases and conditions, weight-loss, fitness, exercise, recipes and natural healing, etc.

4.3.2 Institutional Sources:

Institutional sources play a vital role in disseminating health information to urban women. State Government or local Governments have set up information centers to disseminate information required by the urban people of the area. Women consult various institutional resources for supporting their various health information requirements. Preferred institutional sources are associations and Learned Organizations, Self Help Groups, Non Government Organizations, Library, Research Centre, Government office, Urban Health center, Health and Family welfare Department, Hospitals. Women organizations, Primary Health Centers, Community Health Centers, Health Institutions/ Associations, Public Health Centers, Natural care centers, District Surveillance Unit, Mobile Health Clinic, etc.

Figure 4.1 Indicates how health information flows in Karnataka and reach to the common man and urban women. Government of Karnataka has so many sections and various departments through this government disseminating health information to the people who live in even remote places.

Figure 4.1 Flow chart indicating how health information flows in Karnataka state



Government departments and agencies publish lots of information in print and electronic formats. Governments at all levels play an important role in producing information for the society they serve. In many occasions, Government officials may need information about the society in order to make decisions relating to economic, social and political issues (Bolner and Gayle,1997).

Some of the information produced by Government is grey literature comprising reports such as National HIV/AIDS reports, gazettes, population statistics, census data, Government notices, policy documents, etc. This can be done through the various Government agencies including the public libraries or the Government websites.

Figure 4.1 shows that how health information about Government of Karnataka state activities reaches the common people. Government of Karnataka has various departments. These departments disseminate information to common people and mainly health information disseminate through department of women and child development, health and family welfare, department of information and publicity, department of medical education, etc.

Through Government, Public information such as that from the Ministry of health and family welfare is useful because people in charge of public health can evaluate correctly the importance of the disease and address the social problem it raises. With the help of pharmaceutical industry, patients should be well informed about the active ingredients in the medicines they use to fight their disease.

4.3.3 Human Sources:

Formal and informal channels are used to communicate health information. But, the flow of information is faster through informal channels. Human sources constitute the major preferred method for urban area. A majority of the women preferred the most traditional method of expressing their feelings through discussion with friends or in an interested group.

Whenever a person has any health problem or wants guidance on health or help, he or she prefers the discussion with the people around him or her. Most of the women preferred doctors to librarians as a source of health information. Neighbours, friends, family members are the top three most preferred human resources by women for supporting their health information requirements. Other human sources are social workers, teachers, concerned professionals, librarian, Government information officers, health care professionals including pharmacists, physicians, nurses, health workers, chemists, doctors, traditional healer, taluk health officers, social workers, medical officers, etc. formed important sources of health information.

Similarly with general health information, health care professionals are the most common sources for getting health information. Physicians have the most personal and direct contact with patient. The most useful information source is good, knowledgeable and experienced physician who will take the time to answer questions and share new findings. There are many physicians who care about patients but simply do not have the diagnostic skills and specialized knowledge to treat the diversity of conditions which they face every day. Lacking specialized information, the useful thing a medical professional can do is help patients locate doctors who are specialist in a particular illness and on the cutting edge of research. Nurses are very helpful in giving an opinion or making an observation. They observe daily and offer comments, views and recommendations. They monitor observe closely and report to the doctor the progress made which helps in prescription of drugs.

4.3.4 Internet:

Searching health information on web (internet) has become an integral part of today's world, and many people turn to the Web for healthcare information and healthcare assessment (Sushmita and Si-Chi, 2014). Internet as a valuable medium of communication both for reaching people by email and for broadcasting of information from a website. Many print and web documents available in internet, some of whom have their own Websites/pages. Some individuals disseminate health information through Facebook, Twitter, Blogs, WhatsApp, You-tube, etc. while others publish health information in print as text books, monographs or articles in journals, magazines or newsletters.

4.3.4.1 Availability of Health Information on Internet:

A great variety of information resources are now available and accessible online. These include search engines like Google, Yahoo, Alta Vista, Lycos, Mama, etc.; databases like MEDLINE/PubMed, Scopus, Web of Knowledge, EMBASE, African Index Medicus; portals, gateways, digital archives, libraries and institutional repositories. Recent, reliable, quality and up-to-date healthcare information are also available in websites of academic and health institutions, professional associations, governmental and non-governmental organizations. In addition, some governmental and not-for-profit organizations such as the National Institutes of Health (NIH) and Bioline International have digital archives which provide free full-text articles. Medical dictionaries, encyclopedias, abstracts and indexes, bibliographies, atlases, videos and drug information sources are also available online (Mckibbon and others, 2007).

A Google search was made to know the availability of health care services information on the internet. An advanced Google search was made and terms like hospitals, nursing home, clinic, dispensary, maternity homes, ambulance, blood banks, laboratory, medical shops, pharmaceuticals, fitness and health clubs were used to search for availability of information on internet. It is noticed that quantitatively the amount of information available on the internet is more but qualitatively it is not satisfactory.

4.3.4.2 Hospitals in Vijayapura City:

The Vijayapura city has three major hospitals Shri B M Patil Medical College Hospital & Research Centre; Al-Ameen Medical College and Government District Hospital. The Government hospital does not have its own hospital website and the remaining two have their websites as a part of their colleges. Shri B M Patil Medical College Hospital & Research Centre website provides information on health services, facilities, additional services and contact information. Al-Ameen Medical College Hospital's website provides information on their services, facilities and contact numbers. The information is available only in English language. Among the private hospitals only four hospitals-Sasnur Hospital (http://sasnurhospitals.com/), Dr. Bidari's Ashwini Hospital (http://www.ashwinihospital. org/), Kidney Foundation (http://drsbpatil.com/) and Ayush Hospital (http://glayushhospital.com/) have their

own websites. Sasnur Hospital's website provides information on full spectrum of women's health care services, facilities, appointment, events, hospital timings, contact details. Dr. Bidari's Ashwini Hospital's website provides information on facilities, special services, corporate service- research and development, 24 x 7 enquiry, make an appointment, preventive health check, pharmacy open 24 x 7, ambulance facilities, contact details. Kidney Foundation's website includes information on specialisation and appointment information, etc. Ayush Hospital's website provides information on facilities, services, specialities, doctors' information and contact information.

Other prominent hospitals information are available on internet through local search engines like www.hospitalkhoj.com, www.justdial.com, www.listbesthospitals.com, www.vijapuraonline.in, www.hospital.cybo.com, www.rainrays.com, www.bijapur.nic.in/tele_index.html, maps.mapmyindia.com/, www.asklaila.com, Only were minimum information like contact details, phone numbers of hospitals and location information, maps, views, votes, reviews and ratings are available. Very few hospitals have provision for appointment through internet.

Prominent individual doctors and consultants like dentist, skin specialities, gynaecologist, dermatologist, paediatrician, psychiatrist, and general physician are also available on internet through the local search engines were minimum information can be found.

The other health care services include pathological and diagnostic laboratories, medical shops, medical instruments vendors, blood banks, fitness and health clubs, etc.

Some of the important ayurvedic hospitals in the city of Vijayapura, offering traditional ayurvedic treatment methods are Nagur Hospital and Ayurvedic College, Government Ayurvedic Hospital, Agnivesh Ayurved Chikitsalaya, Ayurvedic Vidyalaya Hospital, etc. http://www.justdial.com/ a local search engine provides contact information, another local search engine https://www.sehat.com provides list of Ayurvedic hospitals with its profile, doctors list and phone numbers for appointment. But the links when accessed do not provide further results. It provides

reviews, maps; https://www.chikitsa.com avails ask a doctor online facility. http://www.vijapuraonline.in/ and www.asklaila.com provides only contact information of Ayurvedic hospitals.

There are many hospitals in the heritage city of Vijayapura specialized in the advanced treatments of eyes. These hospitals offer the service of specialists in the field of caring and treatment of eyes problems. Some of the famous eye hospitals in the Vijayapura district are Kembavi Eye Hospital, Biradar Eyes Hospital, Anugraha Eye Hospital, etc. http://www.justdial.com/ includes contact information, votes, maps and reviews.

Health clubs are active in the city of Vijayapura to provide proper training and guidance in health care and body fitness. Modern-day health clubs are playing a vital role in giving a boost to the weakening physical stamina. Most of the Fitness clubs offer a wide range of exercise equipments that takes care of both mental stress and health stability. There are many famous gymnasiums, fitness centers and weight loss centers in Vijayapura. Few of the popular fitness centers in Vijayapura are Diamond Gym, Dr Arun's fitness center, Healthline Enterprises, Health Line Fitness Club. Gymnasiums and fitness centers have become a part of life style. http://www.justdial.com/, http://www.vijapuraonline.in/include contact information, maps and reviews. http://maps.mapmyindia.com/ provide map of the health clubs.

Yoga is the better way of living for those who aims to get a healthy mind in a healthy body, thus the ultimate aim of yoga is to help the individual to transcend the self and attain enlightenment. There are many Yoga Centers in Vijayapura which offer a wide variety of special courses on yoga and related topics. The details of yoga and meditation centers in Vijayapura i.e. Prajapita Brahma Kumaris Ishwariya Vishwa Vidyalay. http://www.vijapuraonline.in , http://www.justdial.com/ provides list of yoga centers and contact information.

We all need to know the importance of blood banks. Today most of the hospitals have blood banks attached to them to obtain blood in quick time. Vijayapura district also has many blood banks associated with many hospitals and there is a branch of Indian Red Cross society also providing their services in Vijayapura. The details of blood banks in Vijayapura are District Government Hospital, Dr. BNM

Rural Ayurvedic Medical College, Lions blood bank, Dr. Karigoudars' blood bank, B.M.Patil Medical College, Hospital and Research Centre, Al Ameen Medical College Hospital. The blood banks in Vijayapura are ready to work for 24 hours a day and 365 days a year. Official website of Vijayapura (http://www.bijapur.nic.in/) provides telephonic index on blood banks and www.justdail.com provides contact information of the blood banks.

Majority of the hospital information available in local search engines provide only contact information of the hospital. They don't have their own websites and those that have their own websites don't have Frequently Asked Questions (FAQs). The health information is available only in English language which decreases its usability. Even with the high literacy rate in Vijayapura district we find that the usability of available online information regarding hospitals and health care is not accessed by them. The public use different means to collect information but accessing the online information will be a last option. The reason can be said to be lack of awareness and knowledge about those websites. There is a need to overcome this drawback by creating awareness among public regarding online health care service information.

4.3.4.3 Health Care Service Information:

Health care is the maintenance or improvement of health via the diagnosis, treatment and prevention of disease, illness, injury and other physical and mental and prevention of disease, illness, injury and other physical and mental impairments in human beings. Health care is delivered by health professionals (providers or practitioners) in allied health professions, chiropractic, physician, associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology and other health professions. It includes the work done in providing primary care, secondary care and tertiary care, as well as in public health.

There are many sources of health and medical information on the Internet, and they are growing very quickly. Through Internet we get information on list of hospitals and their address, the most comprehensive list of Doctor's in Vijayapura and booking appointments through online is made accessible. Using the internet to find health and medical information can make us more informed and take right decisions

about our health, although some health information available on the internet can be valuable. Internet users have looked for health information online, with increased interest in diet, fitness, drugs, health insurance, experimental treatments, and particular doctors and hospitals. Gather more information about a medically diagnosed disease or illness. Find out about alternative medical treatments and seek support from other internet users who have the same kind of medical disease or illness (via 'chat rooms', online discussion forums, blogs or communities, or social media such as Facebook), etc (Shobha and Tadasad, 2016).

4.3.4.4 Information on Various Health Schemes by the Government:

The internet is transforming health care, and has the potential to combine all existing health information sources. The general public increasingly uses the internet as a complementary resource for health information (Leung and others, 2007). Govt. of Karnataka has its own website http://www.kar.nic.in/. Through their website it announces the programmes.

NIC-Karnataka has developed and assisted the various Government department in Karnataka in implementation various e-Governance projects. Some of the important ones are RDS, Samaya Mahiti, e-granthalaya, Sahakaradarpana, Sarathi and Vahan, Bhoomi, RFS, e-man Aaasti Terige, Mukhyavahini, Balasharma, Krishi Maratavahini, Ahara, AMS, etc.

It also covers Sites @ Karnataka (Government departments, Organisations, Boards and Corporations, Judiciary and commission, Educational, District and others), External Links (Rural Development and Panchayat Raj, Karnataka Government, Indian Railway, Indian Airlines, Department of IT, Citizen Charters, Right to Information Act, Government Policies India, etc.). It has played a pivotal role in steering e-Governance applications in the Governmental departments at national, state and district levels, enabling the improvement in a wider transparency of Government services.

Government of Karnataka has provided all their information on their website and also some useful links which will help citizens and many other to get more information on the state. Some of the departments and websites are given below:

Department of Health and Family Welfare: Karnataka state is one of the pioneer states in the country in providing comprehensive public health services to its people. Even before the concept of primary health centers was conceived by the Government of India, the state had already made a beginning in establishing a number of PHU's for providing comprehensive health care, and a delivery system consisting of curative, preventive, promotive and rehabilitation health care, to the people of the state. "HEALTH" is an asset to every person. (URL: http://karhfw.gov.in)

Department of Women & Child Development: The Department of Women and Child Development under the Ministry of Human Resource Development is the key agency for development and welfare of women and children. Most of the provincial governments also carry out women related activities through Social Welfare Departments. Ministry of Human Resource Development and Ministry of Information Technology have formulated a number of schemes, particularly in the area of education and training in ICT. These schemes can succeed with gender-sensitivity and removal of regional biases. The Department is responsible for the welfare and development of women, children, and elderly and disabled in the State. Besides implementing developmental programmes, it formulates necessary policies, programmes and schemes and also co-ordinates the efforts of both Governmental and Non-Governmental organisations working in the field of women, children, elderly and disabled. (URL: http://dwcd.kar.nic.in).

Department websites will facilitate online access to the available information. The website should be periodically updated with new information.

4.4. BIJAPUR (NOW VIJAYAPURA) AT A GLANCE:

Bijapur (Now Vijayapura) district is a district in the state of Karnataka. The city of Vijayapura is the headquarters of the district, and is located 530 km northwest of Bengaluru. Vijayapura is a border district of Karnataka state. Its earlier named was Bijapur and in 2014 it was renamed as Vijayapura. It is well known for the great monu-ments of historical importance built during the Adil Shahi dynasty. The foundation of this historic city was laid during the reign of the Chalukyan dynasty of Kalyani between the 10th and 11th centuries. They called it Vijayapura or the City of Victory.

The geographical location of Vijayapura district in Karnataka state is as under.

Figure 4.2: Location of Vijayapura in Karnataka

Vijayapura district has an area of 10541 square kilometres. It consists 5.49% of Karnataka state area. It is bounded on the east by Kalaburagi district, on the southeast by Raichur district, on the south and southwest by Bagalkot district and on the west by Belagavi district and by the Maharashtra of Sangli on the northwest and Sholapur on the north, Sangli on the north-west (both of Maharashtra state).

Figure 4.3: Vijayapura District Map

Vijayapura (Formerly known as Bijapur district with headquarters at Bijapur) having jurisdiction over five talukas namely Basavan Bagewadi, Vijayapura, Indi, Muddebihal and Sindagi (Bijapur District, 2015). Now the district has been reorganised into twelve talukas namely Vijayapura, Basavan Bagewadi, Indi, Muddebihal, Sindagi, Talikote, Chadchan, Devar Hipparagi, Kolhar, Nidagundi, Babaleshwar, Tikota with effect from November 1, 2017.

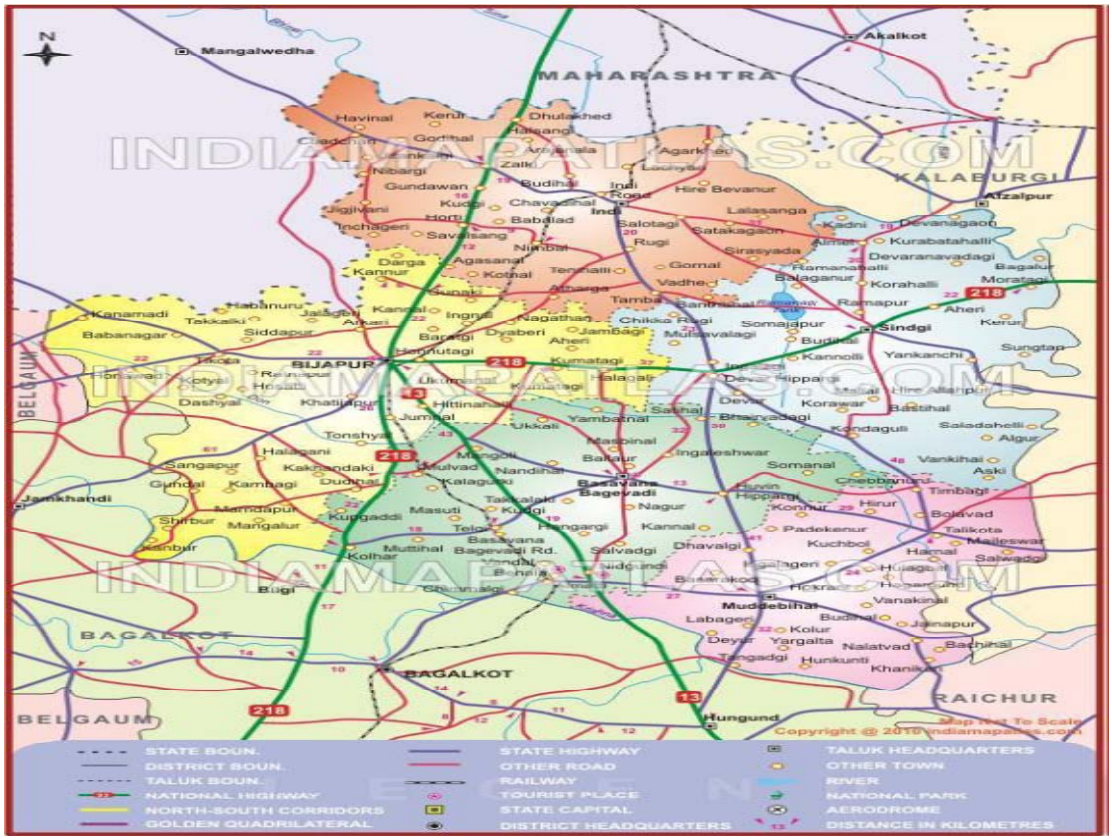
There are 692 villages, 680 inhabited, 12 uninhabited and six statutory towns in the district. The city has population of 326,360 as per 2011 census among which male population is 1,65,122 and female population is 1,61,238. Total literacy rate of the city is 73.42 (239631) which is less than the state literacy rate (75.36) and the literacy rate among men is 77.89 (128615) and among women it is 68.85 (111016) which slightly higher than the state literacy rate (68.1) among women. Vijayapura taluk has highest literacy rate, i.e. 71.87 percent and Sindagi has recorded lowest rate, .i.e. 62.90 percent.

Traditionally, there is always a gap between rural-urban literacy rates, where, the urban literacy rates are higher than rural literacy rates. The differences may be due to historical factors. Too much of a gap between rural-urban literacy rate brings down the overall literacy. Vijayapura is considered as an industrially backward district. The major reasons for its backwardness are lack of adequate initiatives, poor infrastructure, scarcity of water, absence of mineral resources and poor connectivity. (Vijayapura District Human Development Report, 2014).

Geographically, the district lies in the tract of the Deccan Plateaus. The lands of the district can be broadly divided into three zones: the northern belt consisting of the northern parts of Vijayapura Taluks of Indi and Sindagi; the central belt consisting of Vijayapura city;

The geographical Map of Vijayapura city and District is as under.

Figure 4.4: Vijayapura City and District



4.4.1 Health Profile of Vijayapura District:

Health plays a vital role in keeping a sound body and mind. Ill health not only spoils the life but also makes man's life miserable. Through being healthy is an innate character of an individual, on many occasion's environment, pollution and pathogenic micro organisms play a very big role in spreading diseases. "Health is wealth" is a well-known proverb. Hence the saying, "Health is poor, man's riches and a rich man's bliss". Earlier there was no organized attempt to meet the challenges of health in community as a whole. Starting with home remedies the medical sciences through research has undergone evolutionary changes. As a result of which several systems of medicine came into existence namely Ayurveda, Unani, Siddha, Allopathy, Homeopathy, etc. the home remedies were not only helpful in getting relief from sufferings but also helped as a cure. Gradually, public health care centers and hospitals were established to provide suitable medical aid in an organized way.

Being a dry area, Vijayapura district major areas is being drought stricken and due to the severe temperature prevailing during summer. The Bijapur (Now

Vijayapura) sultan Adilshahi being very considerate about the public health took a lot of interest in establishing Ayurvedic and Unani hospitals. But the rural population was deprived of these systematic services. The rural population was using home remedies. In every village, some families had expertise in the traditional knowledge of herbal medicine. It is these families that provided a cure to many diseases and were the professionals. They used the local roots and herbs for the preparation of medicines. In the later part of 19th century, when the East India Company was established, the British introduced the western all opathic system of medicine. This system was restricted to the British army only. But later, it was gradually extended to the locals also. Modernization and industrialization have brought about changes in the life style of people. As a result, health hazards like cancer, heart related problems, AIDS, blindness, polio, etc., began. These are the bothering illnesses of the people. As a result, the health and medical services have undergon continuous changes to meet the new demands (www.karnataka.gov.in).

The city of Vijayapura is a major city in the vicinity of 100 km radius having advanced level medical facilities around the clock throughout the year. Its history of providing medical facilities dates back to medieval periods by 'ayurvedic vaid' and later during Adilshahis period by 'Unani hakims'. The first ever allopathic dispensary was started in the year 1871. Over a period of 135 years the number of hospitals and the quantity of health services provided to the people in the city has a seen a remarkable growth. After independence the Government of Karnataka opened many hospitals. Similarly private hospitals, clinics, and multi-specialty hospitals have been established in a very large number.

Table 4.2: No. of Government Hospitals (Hq.) and Beds in Vijayapura District

Sl. No	Taluks	Taluka Hq. Hospitals		District Hospitals		Total	
		Nos.	Beds	Nos.	Beds	Nos.	Beds
1	B.Bagewadi	1	100	-	-	1	100
2	Vijayapura	-	-	1	420	1	420
3	Indi	1	100	-	-	1	100
4	Muddebihal	1	100	-	-	1	100
5	Sindagi	1	100	-	-	1	100
	Total	**4**	**400**	**1**	**420**	**5**	**820**

Source: District Health and Family welfare Department, 2011-12

Table 4.3: Government and Private Doctors and Beds in Vijayapura District

Sl. No	Taluks	No. Hospital				No. of Doctors				No. of Beds		
		Govt.	Private		Total	Govt.	Private		Total	Govt.	Private Nursing Home and Hospital	Total
			Nursing home/ Hospitals	Clinics			Nursing home/ Hospitals	Clinics				
1	B.Bagewadi	15	1	49	65	22	1	49	72	214	20	234
2	Vijayapura	19	63	344	426	43	63	344	450	516	1500	2016
3	Indi	17	5	96	118	19	5	96	120	232	80	312
4	Muddebihal	13	2	24	39	17	2	24	43	238	40	278
5	Sindagi	13	5	56	74	18	5	56	79	238	80	318
	Total	**77**	**76**	**569**	**722**	**119**	**76**	**569**	**764**	**1438**	**1720**	**3158**

Source: District Health and Family welfare Department, 2011-12

Table 4.4: Health Benefits in Vijayapura District

Sl.No	Taluks	No. of Benefits in Jananni Suraksh Yojana	No. of Benefits Madilu Kit
1	B.Bagewadi	4084	2535
2	Vijayapura	3662	1937
3	Indi	3222	2249
4	Muddebihal	1360	1698
5	Sindagi	3526	2774
	Total	**15854**	**11193**

Source: District Health and Family welfare Department, 2011-12

Table 4.5: Immunisation programes in Vijayapura District

Sl. No	Taluks	D.P.T			Polio			BCG			Measles			T.T	Hepatitis 'B'
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
1	B.Bagewadi	4661	4302	8963	4661	4302	8963	4617	4280	8897	4185	3864	8049	9669	8098
2	Vijayapura	6338	5850	12188	6342	5854	12196	5990	5530	11520	5696	5257	10953	13475	9866
3	Indi	5695	5262	10957	5698	5259	10957	6824	6299	13123	5160	4764	9924	12684	9116
4	Muddebihal	3699	3414	7113	3634	3354	6988	3761	3472	7233	3547	3274	6821	7545	6206
5	Sindagi	5246	4842	10088	5246	4842	10088	5610	5179	10789	4893	4517	9410	11013	8043
	Total	**25639**	**23670**	**49309**	**25581**	**23611**	**49192**	**26802**	**24760**	**51562**	**23481**	**21676**	**45157**	**54386**	**41329**

Source: District Health and Family welfare Department, 2011-12

In Vijayapura district health care facilities and services are made available and accessible through CHCs, PHCs and taluk hospitals in rural and urban areas can be noticed. The PPP mode has improved overall healthcare facilities and services in Vijayapura district (Vijayapura District Human Development Report, 2014).

Table 4.6: Taluk wise details of Health centers 2011-12

Sl. No	Taluks	Allopathic Hospitals	Indian System of Medicine Hospitals	Private Hospitals	Primary Health Centers	Community Health Centers
1	Basavana Bagewadi	2	-	1	14	1
2	Indi	4	-	5	14	2
3	Muddebhihal	3	-	2	9	3
4	Sindagi	2	-	5	9	3
5	Vijayapura	63	1	63	14	-
	Total	**74**	**1**	**76**	**60**	**9**

From the table contains data pertaining to health centers in different taluks of Vijayapura district and table shows that, in the year 2011-12, there were 74 Allopathic hospitals. Further, there is 1 Indian system of medicine hospital, 60 primary health centers, 76 private hospitals and 9 community health centers. An important issue from human development point of view is that for better health people, should have access to medical facilities. In Vijayapura district each taluk has more than one primary and community health centres. Basavana Bagewadi, Vijayapura and Indi taluks have 14 each primary centres. Muddebhihal and Sindagi have 9 each primary centres.

Over the years, the number of hospitals, doctors, paramedical and diagnostic facilities has improved in the city. The establishment of allopathic medical colleges, ayurvedic medical colleges and Unani medical college has greatly helped the people. In addition a number of private hospitals have also come up, some of which private hospitals have advanced medical facilities. Despite this, it is found that a good number of patients rush to Solapur and Miraj for treatment. Even some of the local doctors are found suggesting their patients to rush to Solapur. On a visit to different hospitals in Solapur, it was found that in some of the major hospitals 15-20 percent of patients are from North Karnataka, especially from Kalaburagi and Vijayapura. This is an indication of deficient medical services. This situation needs introspection and immediate attention of the government as well as the private medical health service providers. The number of doctors and the number of ambulances also affect the provision of health services. At the national level, population-doctor ratio is 1:2000.

In respect of ambulances, the norm is one ambulance for every one lakh persons. Compared to the national norm, in Vijayapura district this norm is better. It works out to be one doctor for every 2200 persons. (Vijayapura District Human Development Report, 2014).

Presently the Vijayapura city has many prominent hospitals in the city including B M Patil Medical College, Hospital and Research Centre; Kidney Foundation; Choudhari Hospital; ESI Hospitals and Diagnostic Centre; District Government Hospital; Al Ameen Medical College and Hospital; City Hospital; Kundaragi Hospital; Matoshree Hospital; Mulwad Hospital; Dr. Bidari's Ashwini Hospital; Regional Neuroscience Center; Government Ayurvedic Hospital; Nagur Hospital, etc.

They do provide highly advanced health services and also encourage health tourism in the city. Besides this, there are hundreds of private hospitals that provide health care services. The city has many multi-specialty hospitals and a range of isolated specialised clinics - children specialists, ENT, dermatologists, maternity, neurologists, psychiatrists, orthopaedics etc. Besides this the city has many blood banks, ambulance services, pathological and diagnostic laboratories, health clubs, nursing homes, maternity homes, pharmaceutical vendors, health care instrument vendors and hundreds of medical shops. Every agency is committed to provide mandatory information to the community itself.

Figure 4.5: Health Institutions in Vijayapura District

Location of Health Institions in Vijayapura District

4.4.2 Health facilities and services:

The public hospitals in Vijayapura city are providing best services for the development of the health of people and along with their services; they are facing few of the challenges. In Vijayapura city, there are five Government Health Centres, of which one District Health Centre and four Community Health Centres are functioning. The Community Health Centres (CHCs) are located at Tasbawdi (Navabagh), Shantinagar, Yogapur and Dargajail areas of the city. These health centres are providing many of the health services and also organizing many of the health awareness programmes in Vijayapura city. The District Health Centre is well equipped with modern equipments promoting health of the people of the city and the statistics pertaining to District Health Centre of Vijayapura is as under.

Table 4.7: Statistics of District Health Centre, Vijayapura

Sl. No	Facilities/ Services	No's
1	Number of Beds	526
2	Ambulance (From 2008-2013)	03
3	Male Surgical	01
4	Female Surgical	01
5	Male Medical	01
6	Female Medical	01
7	Geriatric Room	01
8	Special Rooms/ Ward	01
9	Maternity Wards	02
10	Geriatric Wards	01
11	NICU	01
12	PICU	01
13	NRC	01
14	ICU	01
15	Diagnostics	01
16	Patriarchy	01
17	Trauma Ward	01
18	Anthropoids	01
19	Eye Ward	01
20	Office Rooms	07
21	Nursing Training Centres	02
22	General Ward and Other Uses	14

Source : (1) Data Provided by District Health Centre, Bijapur as on November 2013.
(2) District Surveillance Unit.

Presently, District hospital constitutes total 52 wards, 03 ambulances and 526 beds. Further, there are also one Male Surgical Room, one Female Surgical Room, one Male Medical Room, one Female Medical Room, one Geriatric Room, total twelve Special Rooms, one Maternity Room, one Trauma ward, one Anthropoids Room, one Eye Care ward, seven Office Rooms, two Nursing Training Centres, fourteen General Wards and seven Office Rooms in the Hospital.

The Government of Karnataka has formulated many of the programmes so as to reduce the maternal mortality. The statistics pertaining to the beneficiaries of these programmes in Vijayapura city are presented in the following table.

Table 4.8: Progress of Various Health Programmes in Vijayapura city

Sl. No.	Programme	2010-11	2011-12	2012-13	2013-14 (Up to July 2013)	Total
1	Prasuti Araike	69	75	95	25	264
2	Madilu	705	917	1151	578	3351
3	Tayi Bhagya	441	138	--	--	579
4	Janani Suraksha Yojana	636	1052	1274	502	3464
5	Dialysis	--	--	--	479	479

Source: District Health Centre, Bijapur, December 2013.

4.4.3 Infrastructure and Health Personnel Facility:

There are two types of hospitals, namely Government and private hospitals. It is our experience that compared with the Government hospitals the number of private hospitals is on the rise. Even though treatment there is costly, yet more patients prefer private hospitals simply because of better facilities which includes among others, the number of beds and doctors.

The private hospitals (clinics+nursing homes) are more in Vijayapura taluk. There are 407 private hospitals. The main reason is the presence of two medical colleges with their research centres. While there are only 05 public hospitals, the number of private hospitals is 645 in Vijayapura district include all the five taluks.

This highlights the need for establishing more Government hospitals. In the interest of access to and availability of medical facilities, it is necessary that the government should play a more proactive role. In the interest of better provision of health facilities, it is necessary that these ratios should be brought down. This requires huge investment and a proactive role by the Government (Vijayapura District Human Development Report, 2014).

4.4.4 District Hospital, Vijayapura:

Established as a civil hospital in 1885, the district originally had started as an allopathic clinic during 1875. Treatment was given to the patients suffering from malaria, diarrhoea and respiratory problems. The hospital was upgraded as a well equipped district hospital. The same hospital was shifted to this new complex. This new hospital complex has more capacity of beds.

The hospital has the Departments of Medicine, Surgery, Gynecology, Pediatrics, Orthopedic, Ophthalomology, Dentistry, ENT, Dermatology and Venereal Diseases, Immunology and Microbiology, X-ray and Anesthesiology. Is also has the units of naturopathy, trauma and accident, blood bank, radiology, I.V. fluid. Under the hospital administration there is a nurse training center.

4.4.5 Rural Health Programme:

After independence, when five-year plan was introduced, medical services and several other programs were extended to the rural areas. Better medical facilities, improving the quality of medical investigations, maternity services, child care, controlling and prevention of communicable diseases were some of the steps taken under the rural health program under the guidance of the Central Government to popularise the family planning. Primary health centers were elevated as community health centers.

4.4.6 Community Health Centers:

In general, Government has opened community health centers in taluk centers/town centers in each district. Community health center is one where the Government has established 30 beds hospital for every 4 health centers or for every population of 1 lakh. Secondary health centers have the provision for 59 beds. These centers in turn refer to community health centers. Here, special medical services are provided. In this district, there were 9 community health centers during 2010-11. These centers are providing medical services to people.

4.4.7 Primary Health Centers:

The Government has established primary health centers to provide the basic health services to the people of rural areas. The services rendered by this center include the protection of public health, taking preventive measures to combat communicable diseases. Both national and state level eradication programs for infectious diseases like TB, leprosy, malaria and vaccination and family planning programmes etc are conducted by these centers. Initially, these were central and state primary health centers. Later, in 1957, Government of India modified these as model health centers.

4.4.8 Primary Health Units:

The health centers like Clinics, Municipal Hospitals, Local Fund Hospitals, Taluk Board Hospitals and Ayurvedic Hospitals were the health centers in rural areas in earlier days. In 1978 the Government charged these hospitals into primary health units. These units undertake the responsibilities of medical services and public health programs like health centers. They also take part in conducting national health and public health educational programs. There is one such health unit for every 15 to 20 thousand population. These units collect data of health programs conducted in their respective areas. The data collected are sent to their respective health centers. Each health unit includes 1 medical officer, pharmacists and nurses.

4.4.9 Family Welfare:

In the year 1949 with the establishment of National Family Planning Society, Family Welfare Scheme was started in India for the first time. Later, in 1952, this program was officially declared as a national program and also enforced family planning scheme. As a part of public health, Family welfare program has been implemented throughout the country.

Under the Family Welfare and Mother - Child Health Services Scheme, the program aims at creating healthy society and to educate the public about the importance of small family and also make them accept family panning voluntarily. Initially, it was introduced at an experimental level and later during the third five year plan the program was extended throughout the district. A full-fledged department of family planning was established in the year 1966. The primary health centers and units, city family centers, general hospitals and community health centers play a great role in the success of this program. Family planning program later considered under family welfare program. In the year 1978, district health and family welfare department was established with the creation of the post of district medical officer in Vijayapura district. The entire district health programs are carried over under the supervision and direction of the district health and family welfare officer. The officer is also responsible for implementing the same at national and state levels with the help of health and medical institutions in the district. The family welfare programs are conducted successfully in the district with the active participation of the government, quasi and private medical institutions.

Special officers have been appointed at district health family welfare office to facilitate a suitable step of vaccination under this mother-child health program. Children are vaccinated against dreadful diseases like whooping cough, tetanus, polio, T.B., measles, typhoid etc. In Vijayapura district, primary health centers an units, community health centers and pregnant women health centers are also established under this program.

In 1973, a branch of this society was started in Vijayapura. Educating the population methods of family planning. Women's education and self employment schemes are some of the major activities of this society. The society aims to focus on taking family welfare services in and around Vijayapura. This includes IUD's, oral contraception, providing health services to mother and child. Branch manager will be the head and there are totally 28 staff that includes a lady doctor, population educator, area manager and area workers. The education program involves conducting seminars, awareness camps and video and film shows. Women's development activities are run through women's information center.

4.4.10 Family Welfare Committee:

District and taluk level family welfare committee are working in Vijayapura district. District deputy commissioner, assistant commissioner and tahasildar are the president of these boards. They meet once in a month and decide to provide compensation to the family member of the diseased during the family welfare operation. Family welfare bureau functions in the office of the district health and family welfare officer and the family welfare officer will be the head of this bureau. This includes the departments of statistics, education and sterilisation. In the department of statistics, there will be one assistant statistician who surveys the district family welfare statistics. In the department of education district medical education officer and area medical educators organize family welfare programs like training and popularizing the schemes through advertisement.

4.4.11 All Indian Medical Institute:

This was established in1942. It has branches throughout the state. The central branch of this institute in Vijayapura has 60 life members. This unit organizes and extends public health services. Clean environment programs, special lectures and debates for doctors. It also encourages the members to take active participation in national health programs. Thus it involves the members to initiate family welfare, mother-child health care and public vaccination programs. It promotes the cooperative involvement of programs like sterilization, eye test, blood donations camp, immunization, etc.

4.4.12 Drug Control:

Manufacturing and marketing of drugs in the state plays a major role in protecting the public health. The Government aims at providing quality drugs at affordable price, through the drug control board. The board functions with three wings as below:

1. Administration and regulation of act.
2. Drug testing laboratory.
3. Pharmacy education programme.

As per the drugs and cosmetics act 1940, office of the district drug controller is regulating and supplying quality drugs to consumers. The drug inspectors have to work at district level. They survey all the manufacturers and distributors of drug and cosmetics. They also have the responsibility of supplying the drugs at controlled rate, sanctioning of licenses prevention of adulterated drugs, testing for the quality drugs and cosmetics (www.karnataka.gov.in).

4.4.13 Various Health Schemes by the Government:

There are certain schemes run and supported by the state and central governments, such as ESI, Vajpayee Arogyasri, Arogya Bhagya yojane, Yashasvini, Janani Suraksha, etc. Vajpayee Aarogyasri is a unique health insurance scheme being implemented by Government of Karnataka. The scheme provides financial assistance to urban poor families to meet their health needs. Serious diseases affecting heart, kidney, cancer, brain hemorrhage, burns and accident cases, etc., are covered under

the scheme. Karnataka Government has introduced another unique scheme called Arogya Bhagya Yojane to its police personnel and their families, which was launched in June 2002. This is a self-financing scheme managed through monthly contribution. Yashasvini scheme is open to all the members of the rural co-operative society, members of self help group/stree shakti groups having financial transaction with the cooperative society/banks, members of weavers, beedi workers and fisherman cooperative societies. The scheme has been designed so that women belonging to BPL families can avail totally cashless treatment in private hospitals. Janani suraksha scheme is the continuation of the previous, delivery allowance, scheme of the central Government. The objective is to provide financial assistance to the poor pregnant women during delivery.

State Government employee scheme is available in all hospitals whereas Vajpayee Arogyasri is available in all taluks except Basavana Bagewadi. Arogya Bhagya Yojane is available only in Muddebhihal. But Yeshasvini, Thayi Bhagya, Arogya Bhagya Yojane, central Government employee's scheme, Bal-Sanjeevni, are not available in any taluk hospitals. ASHA, Madilu and NRHM facilities are available in Vijayapura.

Under NRHM the central state Governments are making efforts to improve the reproductive health. This programme aims to increase deliveries at the institutional level and to provide ante-natal care. For this purpose ASHA workers are appointed to provide timely advice to the pregnant women. In this connection in Vijayapura district, in 2012, Rs. 777.74 lakhs was spent. Further, under this programmes 11230 Madilu kits were distributed.

Public health services are of importance for the poor. With this in mind, in 2003 for the benefit of farmers, the central Government introduced health insurance scheme. The Government has recognised certain hospitals for this particular purpose and the expenditure incurred is reimbursed.

The Government district hospital provides preventive, promotive and curative services for all the people in Vijayapura. There are many special units in the district hospitals in Vijayapura. The Government district hospital doesn't has its own website, the facilities, services and details are hence not reachable to the public. The sukshema

project by the Government is one of the health care projects in Vijayapura with a higher prevalence among the people reside in the rural areas of Vijayapura. The information of these available schemes in various hospitals has not received any mention in their websites though these undertake state Government schemes but these schemes are not mentioned in the hospital websites.

In Vijayapura district sincere efforts are made to improve the availability and accessibility of health care facilities and services thought CHCs, PHCs and taluk hospitals in rural and urban areas. In addition to these facilities and services, the Government has also launched health care schemes especially for the poorer sections of the society. These are accessed in government as well as in the private hospitals. Such schemes have reduced the economic burden of poor on quality health care. Immunisation programme is quite satisfactory (Vijayapura District Human Development Report, 2014)

4.4.14 Couple Protection Issues and Family Welfare Programmes:

Under “Health for All” program, the Government has undertaken several steps during the year 2000 by promoting and encouraging more and more research and development projects in medical sciences to eradicate deadly diseases and reduce the death rate in order to create a healthy society. Creation of new health and family welfare departments was the other step taken by the Government in this direction. There has been progressive increase in the outlay on health plan since the first five-year plan. These plans incorporated the general policy for improvement of health with emphasis on control of communicable diseases, improvement of environmental sanitation including urban and rural water supply, provision of maternal and child health services, training programs, health education and nutrition. Efforts are also made to bring into effort the concept of primary and community health center to serve as a base for intensive family health and welfare care. Several public health centers were opened by the Government in taluk and district head quarters in order to achieve remarkable progress in medical services to community (www.karnataka.gov.in).

Family welfare is an integral part of health programmes. Over several decades, in the context of rapidly growing population, the Government of India, state and local Governments have assigned special importance to the family welfare programmes. There are three dimensions of family welfare programmes namely (1) family centres and sub-centres (2) vasectomy and (3) tubectomy.

There were a total of 298 family welfare sub-centeres, of these 72 were located in Vijayapura taluk, followed by Indi (62), Basavana Bagewadi (57), Sindagi (56) and Muddebhihal (51).

It can be inferred that people have now realised the importance of population control and small family. In the long run a small family helps in improving the level of human development. A small family is in a better position to provide education to its members and to arrange for required health needs (Vijayapura District Human Development Report, 2014).

4.4.15 Health Awareness and Rate of Institutional Delivery:

The right to life is one of the fundamental rights. This right can be exercised through easy access to health facilities. Considering this, the central and state Governments have initiated several public health programmes. With the objective of improving women's reproductive health, the central Government has launched National Rural Health Mission (NRHM) in 2005. The public health programmes such as Madilu programmes, Yashaswini Health Insurance Scheme, Tayandira Card, etc., are found beneficial. Accredited Social Health Activists (ASHA) make visits to every village, enquiring about health of pregnant women, lactating mothers and their children (Vijayapura District Human Development Report, 2014).

4.4.16 Governance issues:

Governance is the process of taking decisions and implementing them. Here, people's representatives and officers play a vital role. Besides, local people, farmer's associations, co-operative societies, non-governmental organizations and religious leaders also play important role. Nowadays, media has also started playing a significant role and its impact is found on the Governance.

For good Governance, people's participation is necessary in taking proper decisions and safeguarding people's interest. Active participation and impartiality are also necessary for good Governance. Along with this, it is important that Governance should be people-friendly, within the limits of law, without damaging human rights. Transparency, rational approach, acceptability by all, principle of equality and a responsive administration are the important elements of good Governance. Only such Governance will help the people who are facing discrimination. Good governance will take society from inequality to equality. It will ensure justice to the downtrodden and marginalised sections of the society.

Indices are not available as to know what is meant by 'good governance'. However, it is assumed to be a good governance when people remark that 'work is done without bribe', 'immediate compliance', 'immediate action', 'patient hearing to people's problems' 'solutions given on spot', 'no discrimination', 'without anybody's help work was done', and so on. These remarks will help to understand the nature of governance, good or bad.

Good governance requires that plans and programmes should be implemented honestly and that these should be completed within the prescribed time limit. People friendly administrative atmosphere should prevail. Sympathy towards poor should be the hallmark of governance. Benefits of development should reach the targeted groups. If this happens, both rulers and ruled are benefitted (Vijayapura District Human Development Report, 2014).

4.4.17 Local Governance Structure:

India has a federal structure of governance, namely, centre, state and local. Similarly, local administration is also federal, having three levels, i.e., zilla panchayat, taluk panchayat and gram panchayat.

For local governance and decentralized administration, 73rd and 74th constitutional amendments were carried out. It provided thirty-three percent reservations to women belonging to the backward classes. This process tries to make commoners as people's representatives. In Vijayapura district control over administration still vests with upper caste people who are still powerful. Even though reservation is provided to men and women belonging to backward classes, it is still

difficult to bring transparency in administration by following the democratic principles. The change, however, can be ensured only through democratic methods (Vijayapura District Human Development Report, 2014).

4.4.18 Role of NGOs and other Voluntary Groups:

In such a situation, the NGOs should involve themselves in various activities favouring the voiceless people. The meaningful activities of the NGOs go a long way in supporting and supplementing development programmes. NGOs may be community based organizations, public service organizations, labour organizations, etc.

The World Bank classifies 'NGO' as a citizen-based association that operates independently of Government, usually to deliver resources or serve some social or political purpose. The World Bank classifies NGOs into two types. First, operational NGOs, which are primarily, concerned with the development projects. Secondly, advocacy NGOs that are mainly interested in promoting and supporting a public cause. Further, the World Bank is of the view that the NGOs are 'not-for-profit' groups or associations. They work for humanitarian interests, acting outside the government domain. They pursue the interest of one or more groups through lobbying and, or, direct action. NGOs are usually set up by interested persons. These are normally funded by philanthropic foundations, business-houses and private persons. In some cases, the Government also comes forward in providing financial assistance. The NGOs work for the socio-economic betterment of the poor and the downtrodden. They also raise environmental protection issues, etc. In the following paragraphs an attempt is made to shed light on different NGOs working in Vijayapura district.

a) Vishala Samsthe:

Vishala samsthe works for the development of women and children. This NGO organizes programmes to raise awareness regarding sustainable development among rural people. People are provided information on health, education, agriculture, gender equality, resource management, etc. Vishala samsthe is helping people to become self-sufficient. It is making efforts to empower women and to make them strong enough to face violence against them. In addition to this, Vishala

Samsthe is engaged in raising productivity, protection of local resources, backyard gardening and seed conservation.

Vishala Samsthe is engaged in creating SHGs. These include landless farmers, marginal farmers, women engaged in sheep rearing and goatary and persons from Dalits and lambani communities. This Samsthe has established around 400 SHGs, 34 federations, 22 watershed community development programmes and 100 youth sanghas. In order to promote entrepreneurship among women, Vishala samsthe has established 'seva kendras' which serve five hundred women. Depending on the local need, it encourages use of locally available resources for different types of entrepreneurial activities. In order to promote animal husbandry, it has encouraged goatary.

Vishala samsthe is actively participating in health programmes covering mother and child health care, family planning and adolescent health problems. It is creating awareness about sexually transmitted diseases and reproductive health, particularly among rural women and providing health service in collaboration with other agencies. Rural people are provided with opportunities to participate in different programmes. Sandhya suraksha, age-old pension, yeshaswani cards, ration cards, etc., are provided to women.

a. Shridhar Swami Vidyavardhak Sangha (R) Vijayapura:

This sangha started functioning from 1988-89 with an objective to strive for the welfare of people. It is working for the upliftment of slums in rural and urban areas of Vijayapura district. It is mainly working for the betterment of women. It works in collaboration with the state and central governments and non-government organizations. This Samsthe also runs a labour school wherein in addition to formal education, skill development programmes are also organised. It provides training to the unorganized women from BPL families. In collaboration with Karnataka Women Development Corporation, women are trained in tailoring, kasturi, etc. Necessary follow-up is also carried out so that women are employed uninterrupted.

Women and child welfare department has released an amount of Rs.10,91,1581. In 2004, for the women in districts, this Samsthe started helpline facility in Vijayapura and Sindagi. Women facing domestic violence are provided

necessary protection. It has filed 280 cases and 40 percent cases are settled. In this connection DWCD has released an amount of Rs. 4,76,000. This Samsthe organises health programmes and participates actively in the pulse polio programmes.

b. Rural Development Samsthe:

Rural development samsthe is working in Vijayapura since 2000. It provides different types of training to the members of stree shakthi groups. This samsthe is engaged in the construction of toilets. It is also making efforts to raise water-table in Vijayapura district.

4.5 HEALTH INFORMATION DISSEMINATION MECHANISM:

Information products and services are available, these cannot reach the end-users unless there is a good mechanism for disseminating such information. In our country, the information needed for rural and urban development, are disseminated by various agencies either through formal publications or through designated officials or through libraries and information centers. But the mechanisms are not well established and well developed. The available information often does not reach the end-users at proper time (Chatterjee, 2004).

Women get health information through various sources that are often not geared to their specific requirements. NGOs and the Government departments generate information about women health. The ICT based information systems give pertinent information concerning the rural and urban sector activities but these are still general in nature. Family members and friends are often the main source of information. The male members of the family who have better access to information source often share relevant information (Dasgupta, 2003).

For providing the necessary information support required by women, a proper information dissemination mechanism has to be designed. At present the information is disseminated in the form of product and services. It normally supports women in common. They get information from various sources. Information reaches from Central Government and State Government to the layman through various Departments and Ministries. It flows to the ministries and departments, through state level, district level and block level officials. Through the field level workers the

information reaches the common man. Normally, field level workers are the grass root level officials. Teachers, librarians, doctors, nurses, primary health officers and district health officers, medical officers etc. play vital role in disseminating health information for the common man.

The channels of information available to them are both formal and informal. The formal channels include radio and television, local Government information office, agricultural extension workers, primary health care workers, and public library. Friends and relatives, doctors, neighbors, as well as Non-Governmental Organizations (NGOs) particularly the urban women, have been cited as important informal channels of information (Saleh and Lasisi, 2011).

The mass media provide indirect, one-way communication and include community, national and international radio and television as well as newspapers, magazines, comic books, cinema or other situations where a large number of people can be reached with information without personal contact (http://www.Mineaction.Org). By and large, health information can be disseminated in urban women through a variety of media. These are usually categorized into two broad classes namely the inter-personal and the mass media.

The policies and policy decisions of the Government flows from the Ministers or high level officials of the Government, through press notes or press conferences or advertisements released through newspapers, radio, and television. It also flows through organizing exhibitions, distributing brochures, booklets, posters and banners.

Another recent trend that has been identified is awareness programmes conducted by various departments, hospitals, organized in joint collaboration with universities, colleges, NGOs, and panchayat raj institutions in the state.

The prevailing women scenario is characterized by unemployment, social and environmental degradation, illiteracy and lack of health awareness, non-compatibility in agricultural environmental and macroeconomic policy and absence of appropriate planning in management of resources. Majority of these problems can be resolved only by programmes and action plans supported by motivated local people, performing and conscious Government agencies and dynamic NGO’s.

There are many mass media channels such as magazines, newspaper, radios and televisions providing information to the community. In addition posters are displayed at PHCs and other places, and pamphlets circulated to the community as a part of health education programme are provided for creating health awareness. Further, an individual can acquire information from doctor-patient interaction and with health educators/workers (Yadav, 2004).

4.6 AGENCIES INVOLVED IN HEALTH INFORMATION DISSEMINATION:

Government departments and agencies publish lots of information in print and electronic formats. In various countries of the world, Governments at all levels play an important role in producing information for the society they serve. In many occasions, Government officials may need information about the society in order to make decisions relating to economic, social and political issues. Some of the information produced by Government is grey literature comprising reports such as National HIV/AIDS reports, gazettes, population statistics, census data, government notices, policy documents etc. Since Government documents are generated with public funds, they are made available either free of charge or at low cost. This can be done through the various Government agencies including the public libraries or the government Websites.

4.6.1 Government Health Programmes/Schemes (Department of Health and Family Welfare (Central and State Health Programmes):

The Central Government Health Scheme (CGHS) was started under the Indian Ministry of Health and Family Welfare in 1954 with the objective of providing comprehensive medical care facilities to people. The dispensary is the backbone of the scheme. Instructions on these various matters have been issued from, time to time for the guidance of the specialists and medical Officers. The Central Govt. Health scheme provides comprehensive health care to the CGHS beneficiaries in India. The medical facilities are provided through wellness centres (previously referred to as CGHS Dispensaries) /polyclinics under Allopathic, Ayurveda, Yoga, Unani, Sidha and Homeopathic systems of medicines (www.nhp.gov.in).

Karnataka state is one of the pioneer states in the country in providing comprehensive public health services to its people. Even before the concept of primary health centres was conceived by the Government of India, the state had already made a beginning in this regard by establishing a number of primary health units for providing comprehensive health care delivery system consisting of "Curative" "Preventive", "Promotive" and "Rehabilitation" Health care to the people of the state as "HEALTH" is an asset of every community. The department is rendering the following services as common minimum needs programme through its network of medical and health institutions in the state.

The department of health and family welfare services implements various national and state health programs of public health importance and also provides comprehensive health care services to the people of the state through various health and medical institutions. Programmes are as follows:-

- **Revised National Tuberculosis Control Programme (RNTCP):**

The National TB Control Programme was started in 1962 with the aim to detect cases earliest and treat them. In the district, the programme is implemented through the district Tuberculosis Centre (DTC) and the Primary Health Institutions. The District Tuberculosis Programme (DTP) is supported by the state level organization for the coordination and supervision of the programme.

The main objective of the programme is “Universal access to quality TB diagnosis and treatment for all TB patients in the community”. This entails satisfactory achievement till date, finding un reached TB cases before they can transmit infection and treating all of them more effectively preventing the emergence of MDR TB. Approaches of RNTCP towards universal access of health care are (1) Ensuring early and improved diagnosis of all TB patients, through improving outreach, vigorously expanding case finding efforts among vulnerable population, deploying better diagnostics and by extending services to patients diagnosed and treated in private sector; (2) Improving patients friendly access to high quality treatment for all cases of TB including scaling up treatment for MDR TB nationwide; (3) Re engineering programme system for optimal alignment with NHM block level and human resource development for all health staff (4) Involvement of private sector

new and innovative approaches for the involvement to universal access to TB cure and control; and (5) Enhancement of supervision, monitoring, surveillance and programme operations for continuous quality improvement and accountability for each TB case.

- **National Leprosy Eradication Programme(NLEP):**

The National Leprosy Eradication Programme is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India. National Leprosy Programme is one of the oldest and the most successful National Health Programme. National Leprosy Control Programme was started in 1955.

- **National Vector Borne Disease Control Programme:**

Launched in 2003-04 by merging national anti -malaria control programme, national filaria control programme and kala azar control programmes. Japanese B Encephalitis and Dengue/DHF have also been included in this program directorate of NAMP is the nodal agency for prevention and control of major vector borne diseases

List of Vector Borne Diseases Control Programme Legislations:

1) National Anti - Malaria programme
2) Kala - Azar Control Programme
3) National Filaria Control Programme
4) Japenese Encephilitis Control Programme
5) Dengue and Dengue Hemorrhagic fever

- **National AIDS Control Programme(NACP):**

HIV infection in India is a major challenge with no State free from the virus. HIV/AIDS continues to show itself to be one of India's most complex epidemics - a challenge that goes beyond public health, raising fundamental issues of human rights and threatening development achievements in many areas. The need to prevent the progression of the epidemic and provide care and support for those infected or affected is calling for an unprecedented response from all sections of society. The National AIDS Control Organization, Ministry of Health and Family Welfare has launched the National AIDS Control Programme- II, from December, 1999.

Reflecting the extreme urgency with which HIV prevention and control need to be pursued in India, the AIDS - II project of the National AIDS Control Programme is across all States and Union Territories and a Centrally Sponsored Scheme with 100% financial assistance from Government of India direct to State AIDS Control Societies and selected Municipal Corporations/AIDS Control Societies.

- **Pulse Polio Programme:**

Pulse Polio Immunization programme was launched in India in 1995. Children in the age group of 0-5 years administered polio drops during National and Sub-national immunization rounds (in high risk areas) every year. About 172 million children are immunized during each National Immunization Day (NID).

- **National Tobacco Control Programme (NTCP):**

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. India is the 2nd largest producer and consumer of tobacco and a variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, bidis and cigars, a plethora of smokeless forms of consumption exist in the country.

The Government of India has enacted the national tobacco-control legislation namely, “The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003” in May, 2003. India also ratified the WHO-Framework Convention on Tobacco Control (WHO-FCTC) in February2004. Further, in order to facilitate the effective implementation of the Tobacco Control Law, to bring about greater awareness about the harmful effects of tobacco as well as to fulfill the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Programme (NTCP) in 2007- 08 in 42 districts of 21 States/Union Territories of the country.

- **National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS):**

States have already initiated some of the activities for prevention and control of non communicable diseases (NCDs) especially cancer, diabetes, CVDs and stroke. The Central Govt. proposes to supplement their efforts by providing technical and financial support through National Program for Prevention and Control of Cancer, Diabetes, CVD and Stroke(NPCDCS). The NPCDCS program has two components viz. (i) Cancer (ii) Diabetes, CVDs and Stroke. These two components have been integrated at different levels as far as possible for optimal utilization of the resources. The activities at State, Districts, CHC and Sub Centre level have been planned under the programme and will be closely monitored through NCD cell at different levels.

- **National Programme for Control Treatment of Occupational Diseases:**

Major occupational diseases are Occupational injuries, Occupational lung diseases, Occupational cancers, Occupational dermatoses, Occupational Infections, Occupation toxicology, Occupational mental disorders and others. Occupational health was one of the components of the National Health Policy 1983 and also included in National Health Policy 2002 but very little attention has been paid to mitigate the effect of occupational disease through proper programme. Ministry of Health and Family Welfare, Govt. of India has launched a scheme entitled "National Programme for Control and Treatment of Occupational Diseases" in 1998-99. The National Institute of Occupational Health, Ahmedabad (ICMR) has been identified as the nodal agency for the same.

- **National Programme for Prevention and Control of Deafness (NPPCD):**

Hearing loss is the most common sensory deficit in humans today. The Ministry of Health and Family Welfare, Govt. of India launched the pilot phase of National Program for Prevention and Control of Deafness (from 2006 to 2008) in 10 States and 1 Union Territory in an effort to tackle the high incidence of deafness in the country , in view of the preventable nature of this disability. The Programme was a 100% Centrally Sponsored Scheme during 11th Five Year Plan. However, in as per the 12th Five Year Plan, the Centre and the States will have to pool in resources financial norms of NRHM mutas mutandis. The Programme was initiated in year 2007 on pilot mode in 25 districts of 11 State/UTs. The Programme has been

expanded to 192 districts of 20 States/UTs. In the 12th Plan, it is proposed to expand the Programme to additional 200 districts in a phased manner probably covering all the States and Union territories by March, 2017.

- **National Mental Health Programme:**

The Government of India launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it.

- **National Programme for Control of Blindness:**

The National Programme for Control of Blindness was started in 1976 as a Centrally Sponsored Scheme to counter the problems of Blindness due to various factors and also to reduce the prevalence of Blindness to 0.3% by 2020.

- **Integrated Disease Surveillance Programme(IDSP):**

Integrated Disease Surveillance Programme (IDSP) was launched with World Bank assistance in November 2004 to detect and respond to disease outbreaks quickly. The programme design was planned on a pilot basis in 9 States out of which Karnataka was one. The State has done a considerable improvement in strengthening the surveillance activities at the District and Taluka levels and has been working towards strong surveillance mechanism at the periphery.

- **Integrated Child Development Services (ICDS):**

Integrated Child Development Service (ICDS) scheme was launched on 2nd October, 1975 (5th Five year Plan) in pursuance of the National Policy for Children in 33 experimental blocks. Now the goal is to universalization of ICDS throughout the country.The primary responsibility for the implementation of the programme is with the Department of Women and Child Development, Ministry of Human Resources Development at the Centre and the nodal departments at the state which may be Social Welfare, Rural Development, Tribal Welfare, Health and Family Welfare or Women and Child Development.

- **National Iodine Deficiency Disorders Control Programme:**

Iodine is required for the synthesis of the thyroid hormones, thyroxine (T4) and triiodothyronine (T3) and essential for the normal growth and development and well being of all humans. Deficiency of iodine may cause some disorders like Goiter, Subnormal intelligence, Neuromuscular weakness, Endemic cretinism, Still birth, Hypothyroidism, Defect in vision, hearing, and speech, Spasticity, Intrauterine death, Mental retardation. In 1992, the National Goiter Control Programme (NGCP) was renamed as National Iodine Deficiency Disorder Control Programme (NIDDCP).

- **Mid-Day Meal Programme:**

Mid-Day Meal (MDM) Scheme was launched in primary schools during 1962-63. Mid-Day Meal improves three areas: 1. School attendance 2. Reduced dropouts 3. A beneficial impact on children's nutrition. The Central Government supplies the full requirement of food grains for the programme free of cost. For its implementation in rural areas, Panchayats and Nagarpalikas are also involved or setting up of necessary infrastructure for preparing cooked food. For this purpose NGOs, women's group and parent-teacher councils can be utilized.

- **National Program of Health Care for the Elderly (NPHCE):**

The programme has envisaged to provide promotional, preventive, curative and rehabilitative services in an integrated manner for the Elderly in various Government health facilities. The range of services will include health promotion, preventive services, diagnosis and management of geriatric medical problems (out and in-patient), day care services, rehabilitative services and home based care as needed. Districts will be linked to Regional Geriatric Centres for providing tertiary level care.

- **RMNCH+A:**

The Reproductive and Child Health (RCH) Programme was launched throughout the country on 15th October, 1997. This programme aimed at achieving a status in which women will be able to regulate their fertility, women will be able to go through their pregnancy and child birth safely, the outcome of pregnancies will be successful and will lead to survival and well being of the mother and the child. The

second phase of RCH program i.e. RCH – II was launched on 1st April, 2005 . The main objective of the program was to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes envisioned in the Millennium Development Goals.

RMCH+A approach has been launches in 2013 and it essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilizing health care and services. The RMNCH+A strategic approach has been developed to provide an understanding of 'continuum of care' to ensure equal focus on various life stages.

- **The National Rural Health Mission(NRHM):**

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring and evaluation against standards, convergence of health and related programmes form village level upwards, innovations and flexible financing and also interventions for improving the health indictors.

- **National Urban Health Mission (NUHM):**

The Union Cabinet gave its approval to launch a National Urban Health Mission (NUHM) as a new sub-mission under the over-arching National Health Mission (NHM).

Under the Scheme the following proposals have been approved:

- One Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population
- One Urban Community Health Centre (U-CHC) for five to six U-PHCs in big cities.
- One Auxiliary Nursing Midwives (ANM) for 10,000 population.
- One Accredited Social Health Activist ASHA (community link worker) for 200 to 500 households.

The scheme will focus on primary health care needs of the urban poor. This Mission will be implemented in 779 cities and towns with more than 50,000 population and cover about 7.75 crore people.

NUHM aims to improve the health status of the urban population in general, particularly the poor and other disadvantaged sections by facilitating equitable access to quality health care, through a revamped primary public health care system, targeted outreach services and involvement of the community and urban local bodies.

- **Pradhan Mantri Swasthya Suraksha Yojana (PMSSY):**

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) aims at correcting the imbalances in the availability of affordable healthcare facilities in the different parts of the country in general, and augmenting facilities for quality medical education in the under-served States in particular. The scheme was approved in march 2006.

- **Janani Shishu Suraksha Karyakaram (JSSK):**

In view of the difficulty being faced by the pregnant women and parents of sick new- born along-with high expenditure on delivery and treatment of sick- new-born, Ministry of health and Family Welfare (MoHFW) has taken a major initiative to ensure better facilities for women and child health services. It is an initiative to provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30 days after birth) in Government health institutions in both rural & urban areas. This is 100 % Government of India funded Programme, through National Health Mission. The main aim of this programme is to ensure, totally zero out of expenditure to Pregnant Women to avail free delivery services in Government Hospitals. Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery.

- **Rashtriya Kishor Swasthya Karyakram(RKSK):**

The Ministry of Health & Family Welfare has launched a health programme for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues.

The Rashtriya Kishor Swasthya Karyakram was launched on 7th January, 2014. The key principle of this programme is adolescent participation and leadership, Equity and inclusion, Gender Equity and strategic partnerships with other sectors and stakeholders. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well being and by accessing the services and support they need to do so.

The Rashtriya Kishor Swasthya Karyakram (National Adolescent Health Programme), will comprehensively address the health needs of the 243 million adolescents. It introduces community-based interventions through peer educators, and is underpinned by collaborations with other ministries and state governments.

- **Indira Gandhi Matritva Sehyog Yojana (MoWCD):**

The Indira Gandhi Matritva Sahyog Yojana (IGMSY) is a maternity benefit programme run by the government of India. It was introduced in 2010 and is implemented by the Ministry of Women and Child Development. It is a conditional cash transfer scheme for pregnant and lactating women of 19 years of age or above for the first two live births.

- **Janani Suraksha Yojana (JSY):**

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme is under implementation in all states and Union Territories (UTs), with a special focus on Low Performing States (LPS). Janani Suraksha Yojana was launched in April 2005 by modifying the National Maternity Benefit Scheme (NMBS).

- **Navajat Shishu Suraksha Karyakram:**

The Ministry of Health and Family Welfare launched the Navjaat Shishu Suraksha Karyakram (NSSK) programme. A simple and scalable training module on Basic Newborn Care and Resuscitation has been developed for this programme. This programme provides evidence-based knowledge in improving newborn health. [https://www.nhp.gov.in/]

- **Thayi Bhagya:**

This Programme envisages, totally free Maternal & Child Health Care of all categories of Pregnant Women and Mothers in the State, with the core intention of zero Out of Pocket Expenditure to all women for MCH Services. The goals and objectives of this programme are achieved with main focus on equity, and ensuring quality MCH services which are available, accessible and affordable to all sections of the society. In addition to the said services, BPL, SC and ST category Pregnant Women and Mothers are provided incentives in cash and kind to motivate them to avail MCH Services in Government and Private Hospitals, with the sole intention of reducing Maternal & Infant Morbidity and Mortality. To reduce Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR),empanelled private hospitals in the Backward Districts of Bidar, Gulbarga, Yadgir, Raichur, Koppal, Vijayapura, Bagalkot and Chamarajanagar, are given an incentive of Rs. 3 Lakhs for every 100 deliveries conducted including surgeries. The treatment is free to the patients.

- **Arogya Kavacha (108):**

“Arogya Kavacha” 108 Emergency service was started in the state of Karnataka on November 1, 2008, by the Karnataka Health and Family Welfare Department under a Private Public Partnership through an MOU signed with GVK EMRI. The Role and Mission of ‘108’ is to save lives by providing a comprehensive ‘Emergency Response Service’ to those in Medical, Police or Fire emergencies, through a single integrated number - 108. We operate 24 x 7 and 365 days of the year with a fleet of 711 well equipped ambulances. The ambulances are manned by a trained Emergency Medical Technician (EMT) and a trained driver (Pilot). This service is available across the length and breadth of Karnataka i.e., all the 30 Districts.

This service can be utilized by any individual who requires emergency help (Medical, Police, or Fire) irrespective of his economic status, caste, creed, color, ethnicity, gender, and/or literacy levels. The process of calling for an ambulance is simplified to such an extent that a call to the toll-free number '108' with details of emergency, the number of people involved and the incident location supported with a landmark; would trigger an ambulance dispatch . This is an absolutely free service starting from the phone call till the point of reaching the hospital. 11,58,243 emergencies calls attended, 10,62,221 emergencies attended, 3,38,736 pregnancy related cases are attended during the year 2016-17 and 66,866 lives are saved during the year 2016-17.

- **Suvarna Arogya Chaitanya:**

Under this programme, around one crore school children (both Private and Govt. sector) are medically screened and children needing surgeries are provided surgical treatment at free of cost in empanelled hospitals under Yeshaswini Scheme

- **Madilu:**

This Scheme is being implemented since 2007-08, with 50 % of the budget coming from Government of India, through National Health Mission and the remaining 50 % of the budget is being provided by the State Government. In this programme, a kit containing 19 items which are useful to the post-natal women and her infant is being provided to BPL, SC & ST beneficiaries, who deliver in any Government Hospital in the State. This benefit is provided to all deliveries of BPL, SC & ST women in HPD districts (Bagalkot, Vijayapura, Ballari, Raichur, Koppal, Raichur, Kalaburagi, Yadagiri, Gadag and Chamarajanagar) and for only two live births in the remaining districts of the State. The line items of the kit are being procured from Karnataka Handloom Development Corporation and the soap items are being procured from Karnataka Soaps and Detergents Ltd.

- **Prasooti Araike:**

The scheme is being implemented for the benefit of pregnant women belonging to Below Poverty Line including SC and ST families. This is one of the four components of Samagra Mathru Aarogya Palane (Thayi Bhagya) Scheme, out of which, the three components, Viz., Prasoothi Araike, Thayi Bhagya and Thayi Bhagya Plus are 100 % Government of Karnataka funded schemes. Prasoothi Araike scheme is being implemented from 2007-08 with the objective of providing cash benefits to BPL, SC and ST communities pregnant women, to enable them to take nutritious diet during pregnancy and post-natal period to reduce maternal and infant morbidity and mortality. This scheme is implemented in all the districts of the State, except Kolar and Dharwad. 28 Beneficiaries of this scheme receive cash incentives of Rs.1000 in two installments, the 1st installment is provided to the pregnant women during her 4-6 months' pregnancy and the 2nd installment of Rs.1000 is provided immediately after delivery, if the beneficiary delivers in any Government Hospital in the State. The 2nd installment will include the JSY cash component. From 2014-15, the cash incentives, for the Pregnant Women and Post-natal mothers has been enhanced for SC & ST beneficiaries to Rs. 2000 each.

- **Vajapayee Arogya Shree:**

BPL families who are affected by catastrophic diseases line cancer, cardiology, neurology, renal failure, burns, ploytruma, etc, are provided free cashless treatment in the identified hospitals upto Rs.2.00 lakhs on family floater basis.

- **Bhagyalakshmi Scheme:**

9,09,000 girl children across the state have been medically examined. This is to achieve the aim of gender parity. The scheme is implemented in co-operation with women and child department.

- **Routine Immunization Programme:**

This programme prevents the incidence of vaccine preventable diseases and prevent morbidity and mortality due to V.P.D.

- **Karnataka State AIDS Prevention Society:**

Karnataka State AIDS Prevention Society (KSAPS) was registered as a society on 9th December 1997; it is an autonomous institution and a highest policy-making structure regarding HIV/AIDS in Karnataka, headed by chief minister.

- **Facility Based New Born Care:**

a. New Born Care Corner (NBCC) :1070 NBCC are functioning at all delivery points, as on 2016. Newborn care corners are established in labour rooms and Operation Theatres in all the 24X7 PHCs, CHCs, taluk hospitals and district hospitals.

b. New Born Stabilization Units (NBSU): 166 NBSU are functioning as on 2016. NBSUs have been established in all First Referral Units (FRUs) and Taluk Hospitals.

c. Special Newborn Care Unit (SNCU): 37 SNCUs are functioning as on 2016 at all district hospitals and some high performing Taluk hospitals.

d. SNCU Online Monitoring Software: All 37 SNCUs are now integrated with the SNCU Online Monitoring Software at their units.

- **Integrated Management of Neonatal & Childhood Illnesses (IMNCI):**

IMNCI was first initiated in Raichur in 2005 and expanded in a phased manner to all 31 districts including BBMP as on 2016.

- **Home Based Newborn Care (HBNC):**

ASHAs visit the neonates at least 6 times in the first 42 days after delivery. ASHAs are trained to identify common neonatal illnesses & educate the mothers regarding breast feeding & care of new born.

- **Mother and Child Tracking System:**

A web based pregnant women and child tracking system introduced aiming to provide pre-natal & postnatal care at the door steps of rural poor. So far 56.70 lakhs pregnant women and 34.22lakhs children have been registered under the system.

- **Bike Ambulances:**

The first aid and medical care during the "Platinum Ten Minutes" is paramount to save the life of an accident victim, hence the pioneering attempt to start motorbike ambulance service. The motorbike ambulance service is another pilot and pioneering initiative to ensure first aid to the victims during the Golden Hour. They are useful for negotiating the small streets and heavy traffic in the large urban areas where it would be difficult to move ambulances through crowds. The fleet of high-powered touring motorcycles are available when required to respond to various trauma/medical incidents. Totally 23117 emergencies (minor trauma and accidents) are attended by the bike ambulances from April 2016 to March 2017.

- **Arogya Sahayavani-104:**

The Government of Karnataka has started the Arogya Sahayavani-104 service with the moto of reaching the unreached, to provide all the health care services available in the public sector. "104" is a toll free number through which people can avail consultation for minor ailments, counseling services, information on services available in public health facilities, directory services and grievance redressal.

- **Extended Thayi Bhagya (Plus):**

A cash assistance of Rs. 1000/- for a private hospital delivery is paid to rural SC, ST and BPL women for the first 2 live births in all other districts other than 10 high priority districts in accredited private hospitals.

- **Yeshasvini Cooperative Farmers Health Care Scheme (Yeshasvini Scheme):**

This scheme was introduced by the state Government to the co-operative farmers of Karnataka. The scheme was operationalised with effect from 1st June 2003. Karnataka has become role model state with the introduction of 'Yeshasvini Self Funded Health Care Scheme'. Yeshasvini scheme is one of the largest Self Funded Healthcare Scheme. Offering a low priced product for a wide range of surgical cover, nearly 823 defined surgical procedures to the farmer cooperators and his family members. It is a contributory scheme wherein the beneficiaries contribute a small amount of money every year to avail any possible surgery during the period. The beneficiaries are offered cashless treatment subject to conditions of the scheme at the network hospitals spread across the State of Karnataka.

- **Vajpayee Arogyashree:**

Vajpayee Arogyashree Scheme has been introduced by the State Government stage by stage in the 60 state. Approximately about 99.12 lakh BPL families in the State have now access to multi specialty health care. Right from diagnosis, hospitalization, treatment / surgery and food will be provided free of cost by the super specialty hospitals. The cost of the same will be borne by the Government through the trust. The maximum expenditure ceiling per BPL family per year is Rs. 1.50 lakhs with a floating provision of Rs. 50,000/-. During the financial year 2016-17 Government has spent Rs. 25398.37 Lakhs to provide treatment to 45,803 BPL beneficiaries of the state under this scheme.

- **Rajiv Arogya Bhagya:**

The Rajiv Arogya Bhagya Scheme is being implemented in the state of Karnataka since 20th January 2015, for tertiary care treatment for APL population. Till now, 181 hospitals are implementing this scheme. For the year 2016-17, a total of 3081 claims amounting to 1573.72 lakhs have been settled of patients treated under the scheme.

- **RAB Scheme for Journalists:**

Journalists recognized by information and public relations department and their family members will be provided with free treatment under APL scheme in general ward only, as per G.O no.AKK 61 CGE 2015, Bangalore dated: 16.07.2016. The scheme will cover one journalist plus three family members. The 61 can avail treatment by showing their ID card issued by their department and APL card, at network hospitals empanelled under SAST for the RAB scheme.

- **Jyothi Sanjeevini Scheme:**

The Government of Karnataka has approved a health assurance scheme in 2014, specially designed for state Government employees, named “Jyothi Sanjeevini”. The scheme is implemented from 20/01/2015. It is a comprehensive health care, wherein the scheme provides cashless treatment to all the Government employees and their family dependents through empanelled network of hospitals. Provide quality treatment for catastrophic illnesses for tertiary care. The scheme involving hospitalization, surgery, and other therapies through identified network hospitals.

- **Rastriya Swasthya Bhima Yojane (RSBY):**

Rashtriya Swasthya Bima Yojana is a flagship programme initiated by the Government of India to extend health insurance for the BPL families and other Government of India identified.

- **Indira Suraksha Yojane:**

Indira Suraksha Yojane is launched for the benefit of dependent members of the farmers who had committed suicide in draught situation due to financial crisis in Karnataka during the F.Y 2015-16 and 2016-17. The beneficiaries of the scheme are identified, certified by the concerned district deputy commissioner and the information shared with SAST. The SAST will issue the required ISY Cards to avail the benefits by the members. The scheme is designed to provide free and quality health care services for catastrophic tertiary and secondary illnesses to the beneficiaries under SAST network hospitals.

- **Arogya Jaagruti Abhiyana:**

Accordingly Arogya Jaagruti Abhiyana was planned which included awareness creation of all schemes under health department through Kala Jatha programmes followed by conducting health camps. The Kala Jatha programmes were planned through conduct of street plays, film shows, distribution of pamphlets etc. The responsibility of effectively conducting Kala Jathas in all habitations was entrusted to department of information and publicity. A week after the Kala Jathaprogrammes, special health camps were conducted with involvement of Government & private hospitals. In these camps, people were screened for primary, secondary & tertiary ailments.

- **Arogyamitra:**

For propagation of applicable scheme benefits and to fully guide and assist the SAST patients to avail tertiary treatment, Arogyamitras have been placed in a prominent place in all THCs, CHCs, District Hospitals, all empanelled Government and private hospitals (www.karnataka.gov.in).

- **Pradhana Mantri Bharatiya JanAushadi Pariyojna:**

Making quality medicines available at affordable prices for all, particularly the poor and disadvantaged, through exclusive outlets “Jan Aushadhi Medical Store”, so as to reduce out of pocket expenses in healthcare.

- **Digital Continued Medical Education (CME) Programme**:

The Government of Karnataka, with its objective to ensure Universal Health Coverage and Quality Healthcare to the people in the State, has now entered into an MoU with M/s Omnicuris Healthcare, Bengaluru on 8.8.2017 to provide online Continued Medical Education (CME) to all the in-service Doctors in the Department of Health and Family Welfare, free of charge**.**

- **Kayakalpa:**

Public health care facilities are a major mechanism of social protection to meet the health care needs of large segments of the population. Cleanliness and hygiene in hospitals are critical to preventing infections and also provide patients and visitors with a positive experience and encourages moulding behaviour related to clean environment.

- **Maternal Health:**

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. Most of these complications cannot be predicted and prevented.

- **Nagu-Magu Ambulance:**

To provide drop back facility for PostNatal Mothers and New Born from Government Health Facilities to their residence. 200 drop back vehicles called as "Nagu-Magu" were inaugurated on 5th February 2014. The Nagu-Magu vehicles are deployed one each at the district hospital and taluka level hospitals (www.karnataka.gov.in).

Though so many schemes are in operation, these have not reached to the fullest extent to the end users i.e. women. This is an indication to the fact that due to lack of adequate health information support, women have not used the benefits.

4.6.2 National Health Policy, 2017, Ministry of Health and Family Welfare, Government of India:

The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for the health sector in the Five-Year Plans. Now 14 years after the last health policy, the context has changed in four major ways. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of noncommunicable diseases and some infectious diseases. The second important change is the emergence of a

robust health care industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy responsive to these contextual changes is required. The primary aim of the National Health Policy, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance. NHP 2017 builds on the progress made since the last NHP 2002. The developments have been captured in the document "Backdrop to National Health Policy 2017- Situation Analyses", Ministry of Health & Family Welfare, Government of India.

The policy envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

4.6.2.1 Urban Health Care:

National health policy prioritizes addressing the primary health care needs of the urban population with special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. Policy would also prioritize the utilization of AYUSH personnel in urban health care. Given the large presence of private sector in urban areas, policy recommends exploring the possibilities of developing sustainable models of partnership with for profit and not for profit sector for urban health care delivery. An important focus area of the urban health policy will be achieving convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of

violence and urban stress. These dimensions are also important components of smart cities. Healthcare needs of the people living in the peri urban areas would also be addressed under the NUHM. Further, Non-Communicable Diseases (NCDs) like hyper tension, diabetes which are predominant in the urban areas would be addressed under NUHM, through planned early detection. Better secondary prevention would also be an integral part of the urban health strategy. Improved health seeking behavior, influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism, would also be important components of this strategy (www.nhp.gov.in).

4.7 NATIONAL URBAN HEALTH MISSION:

National Urban Health Mission (NUHM) aims to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships and with the active involvement of the urban local bodies. The main focus of the NUHM will be urban poor population living in listed and unlisted slums, all other vulnerable populations such as homeless, ragpickers, street children, rickshaw pullers, construction, brick, lime kiln workers, commercial sex workers and other temporary migrants. NUHM will cover all the District headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will be covered under NRHM.As per 2011 census, 236.25 lakh people reside in urban areas, and the urban slum population is 36.31 lakhs in Karnataka state. About 31.57% of population live in urban areas of the state and is viewed as challenging. The emphasis is to improve existing public health delivery system with a thrust on making available adequate health human resources, upgrading the 35 existing health facilities in terms of infrastructure and equipment and also establishing new health facilities wherever necessary by providing specialist care as well as strengthening emergency response systems. This will enable the health and family welfare department or city municipalities/corporations to effectively provide adequate primary health care to the urban poor, focus on promotive, preventive, and curative aspects of both communicable and non-communicable diseases, domestic violence on women, and strengthen trauma care and emergency care to the urban poor.

State NUHM took off from latter part of 2013 and the state stands committed to the objectives of the center with a defined fund flow mechanism. A comprehensive baseline survey and mapping is being undertaken (23 cities/towns of the state have completed mapping) to gain insight into the dynamics of health needs of existing listed and unlisted slum pockets, urban poor concentration areas and other vulnerable population. In the coming days, this will help in assessing their health seeking behaviour, health indicators such as morbidity and mortality patterns, ongoing health needs, and existing provisions for health care, out of pocket expenses etc.

One urban primary health centre (UPHC) is functional for every 50,000 population under NUHM. 361 such centers across the state have been functional till date. 263 existing Urban Family Welfare Centre, Urban RCH Centre, Urban Health Centre, Urban Health Post, etc., have be upgraded and strengthened as UPHC. Where none existed, new UPHCs were planned and the District Health Society initiated the process of identification of location/ land. NUHM wing of NHM has been providing both capital and recurrent cost for up gradation and maintenance of the UPHCs, as per the norms. The District Health Society was given liberty to hire premises for new UPHCs where land was not available. So far, 263 PHCs are functioning in their own government building and 98 are functioning in the rented building. This important mission mode programme the National Urban Health Mission - makes preventive care and treatment available to the urban poor and other vulnerable populations free of cost – ensuring a healthy and prosperous future for our cities (www.nhp.gov.in).

4.8 HEALTH AWARENESS:

Health awareness is a process which effects changes in the health practices of people, knowledge and attitude related to such changes. Health awareness is closely connected with imparting of knowledge to the people about the principles of hygiene. It educates people for preserving and developing their physical and mental health. Health awareness is a basic pre-requisite for leading comfortable life. It is true that, one should not diagnose on their own, but at least one can take precautions to keep the routine disease away by reading health related information. In the context, library and information centre plays a significant role in disseminating or creating health awareness among society at large.

Health awareness aims at creating such a quality of life as may enable an individual to live the most and serve the best. In simple words, health awareness is “an art of living”. We practice this art in order to have a sound body and sound mind.

The modern concept of health awareness regards health behavior more important than health knowledge. Therefore, health knowledge must be provided, if we expect the individual to continue to maintain sound health behavior and meet new health problems successfully during adult life. Health awareness is the translation of what is known about health into desirable individual and community behavior pattern by means of educational process. In simple words, health awareness is a process which enables an individual to understand ‘how’ and ‘why’ of matters relating to health.

Health awareness is a very vast term. It has a very wide scope. It is closely related to many other aspects, besides health. Normally, health awareness includes,

1. The balanced and nutritive diet and how it should be prepared.
2. The need for fresh air, water, ventilation, light, physical exercise, recreation, rest and sleep, etc.,
3. The habit of cleanliness with regard to body, bodily organs, dress and dwelling place.
4. Knowledge of the structure of the various organs of the body.
5. Knowledge of the functioning of various systems of the body.
6. Knowledge of various common diseases, their causes, symptoms, precautionary measures and cures.
7. Sanitation, etc.,

Thus we see that the scope of health awareness is very wide indeed. It touches all branches of life, viz., personal life, school life and community life.

For public purpose, mass awareness programmes are required. For developing the backward regions, along with economic programmes, emphasis should be placed on social, educational and health related programmes. Since Vijayapura is drought prone district, ‘area-specific’ and ‘group- specific’ programmes should be developed. It is found that more than sixty percent of population of Vijayapura is dependent on agriculture and since it is difficult to create employment opportunities outside

agriculture, programmes which sustain agricultural development should be implemented (Vijayapura District Human Development Report, 2014).

4.9 CONCLUSION:

Good health is a pre-requisite to human productivity which is an essential factor in the development process. A healthy community is the infrastructure upon which an economically viable society can be built. Unhealthy people can hardly be expected to make any valid contribution towards development and better health is essential for overall development and human happiness in any society. Provision of good health care to the people is ail essential component of development strategy adopted by the state to achieve overall socio-economic development. Vijayapura district made significant progress in improving the health status of the people. However, despite the progress, the state has a long way to go in achieving the desired health goals. The study areas, over the period, have made substantial progress in building credible health infrastructure at different levels. The Karnataka state has a wide institutional network providing health services both in urban and rural areas.

In Karnataka, Vijayapura taluk has comes under the developed group in Vijayapura district, but Basavan Bagewadi and Indi comes in backward group and the rest of talukas are in highly backward groups like Muddebihal and Sindagi. Therefore, it’s indicating that there in lot of disparity with respect of health development in the taluks of Vijayapura.

Now it is well accepted that the health care is the right of the people and as suggested in the directive principles of our constitution it should be provided free of cost to all the people. Hence, improvement of the public health care facilities and regularization of the private healthcare facilities need to proceed hand -in - hand in future in the best interest of the rural and poor households of our country. The improvements outlined above will not only improve the health status of the people but also promote equity and justice in the society. Rapid economic growth of the state shall be hampered without improving the quality life of the people in the country. But, the study clearly shows that, there are regional differences in the health care facilities across the state, districts and taluks. More of them are still poor which need to be strengthened to achieve the real goal of health in the state.

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CHAPTER – 5

DATA ANALYSIS

5.1 INTRODUCTION:

An analysis of data has been made in this chapter based on the data collected from women of Vijayapura city Municipal Corporation. The chapter is divided into five sections. Viz., General information, Needs of urban women's health information, Use of mass media, Knowledge of understanding health problem and Awareness of Government programmes.

The selection of sample respondents has been made from 35 wards of Vijayapura city. From each ward 20 respondents have been selected. For every ward twenty women have been identified by using purposive sampling and the identified women interviewed with the help of using structured questionnaire.

5.2 GENERAL INFORMATION:

Table- 5.1: Age wise distribution of study population (N=700)

Age	Number	Percentage
18 to 25	172	24.6
26 to 45	273	39.0
46 above	255	36.4
Total	**700**	**100.0**

Table 5.1 reveals that large number of women under study belong to the age group of 26 to 45 years (39%, N=273) followed by 46 years above (36.4%, N=255). Nearly one fourth of women respondents belong to the age group of 18 to 25 years (24.6%, N=172). Thus it can be concluded that study population comprises large number of women aged above 26 years.

Table 5.2: Educational qualification wise distribution of study population

Educational qualification	Number	Percentage
Illiterate	42	6.0
Below SSLC	279	39.9
PUC/CLIB/DIP/ITI/BED	90	12.9
Under Graduate	91	13.0
Post Graduate and above	198	28.3
Total	**700**	**100.0**

Table 5.2 provides educational qualification of the urban women under the study. It is found that more than one third of women respondents have studied up to SSLC (39.9%, N=279), while a very small proportion of women under study are illiterates (6%, N=42). On the other hand 28.3% of women have completed their post graduate and above qualification (N=198), followed by 13% (N=91) of urban women completed their under graduation and 12.9% (N=90) of women respondents completed their PUC/CLIB/DIP/ITI/BED. It can be interpreted that women who have studied below SSLC and those who have passed PUC/CLIB/DIP/ITI/BED comprise more than half of the study population.

Table- 5.3: Category wise distribution of study population

Category	Number	Percentage
GM	239	34.1
OBC	319	45.6
SC/ST	142	20.3
Total	**700**	**100.0**

In this study urban women have been categorized into different social classes like GM, OBC and SC/ST. It is found from table 5.3 that, the study population comprises of 45.6% of OBC (N=319), 34.1% of GM (N=239) and 20.3% of SC/ST (N=142) urban women. Thus women belonging to OBC and SC/ST group constitutes nearly two third of population.

Table- 5.4: Marital status wise distribution of population

Marital status	Number	Percentage
Unmarried	228	32.6
Married	472	67.4
Total	**700**	**100.0**

Table 5.4 it can be analysed that more than 67% of urban women under study are married (N=472), this group includes widows, divorcees and those who are staying separately and the remaining 32.6% (N=228) are unmarried. Married women constitute a majority of study population.

Table 5.5: Knowledge of languages among urban women (N=700)

Languages Known	Number	Percentage
Kannada	690	98.6
Hindi	296	42.3
English	239	34.1
Marathi/Urdu/Telugu	91	13.0

One of the objectives of the study was to identify the languages known by the urban women under study (Table 5.5). Kannada being the state language is known by the majority of the urban women (98.6%, N=690). 42.3% of women know Hindi (N=296) and 34.1% (N=239) of urban women know English as well. Marathi/Urdu/Telugu is known to 13% of urban women (N=91).

Table- 5.6: Occupation wise distribution of study population

Occupation	Number	Percentage
In service	193	27.6
Business/ Self employment	46	6.6
Student	145	20.7
Housewives/Unemployed	316	45.1
Total	**700**	**100.0**

Table 5.6 shows that urban women housewives/unemployed (45.1%, N=316) constitute a larger proportion of the study population. More than one fourth of the urban women are in service (27.6%, N=193). While a more than one fifth of women under study are students (20.7%, N=145) and a small percentage of women (6.6%, N=46) are in business/self employment. Housewives/unemployed women are more in number compared to other groups, in the study population.

Table- 5.7: Income (Monthly) wise distribution of study population

Income (In Rupees)	Number	Percentage
No Income	446	63.7
<5000	66	9.4
<10000	100	14.3
>10000	88	12.6
Total	**700**	**100.0**

From table 5.7, it is observed that majority of the respondents under study have no income (63.7%, N=446). Further it can be analysed that 14.3% of women (N=100) under study have monthly income of less than Rs.10,000 and a small percentage of urban women have monthly income of more than Rs. 10,000 (12.6%, N=88). While a more than 9.4% of women (N=66) have monthly income of less than Rs. 5000. A large number of women do not have their own income.

Table 5.8: Availability of media facilities at home (N=700)

Availability	Number	Percentage
Radio	175	25.0
Television	689	98.4
Telephone/Mobile	642	91.7
Newspaper/Magazine	433	61.9

One of the objectives of the study is to know the media facilities available in the houses of urban women. Table 5.8 reveals that Televisions are found in 98.4% of the houses (N=689). More than 91% of urban women have telephone/mobiles (N=642), followed by 61.9% (N=433) of urban women have the facilities of newspapers/magazine and one fourth of women have radio facilities at home (25%, N=175). Thus televisions can be seen in a large number of women's houses.

5.3 HEALTH INFORMATION NEEDS OF URBAN WOMEN:

Table- 5.9: Needs of various types of health information (N=700)

Health Information Needs	Mean	Rank
Hospital and Nursing Home	5.52	1
Nursing	4.96	6
Pharmaceutical	4.79	8
Obstetrics	4.49	12
Birth control	4.71	9
Diseases	4.59	10
Prevention of diseases in general	4.58	11
Surgery & Therapeutics	4.32	13
Public hygiene	4.93	7
Personal hygiene	5.13	5
Food	5.52	1
Diet regulation	5.22	3
Physical fitness	5.21	4
Etiology	4.01	14
Pathology	3.91	15

One of the objectives of the study is to know the health information needs of urban women. Various types of health information needs have been listed and women were asked to rate the importance on a six point scale (1-Highly unimportant, 2-Unimportant, 3-Moderately unimportant, 4-Moderately important, 5-Important and 6-Highly important) and the details of the calculated mean is given in Table 5.9. Based on the mean value rankings were given. The ranking of health information need indicates that hospital and nursing home, food and diet regulation are the top three ranked health information needs of urban women. Physical fitness, personal hygiene and nursing are ranked 4^{th}, 5^{th} and 6^{th} respectively. Public hygiene, pharmaceutical, birth control and diseases occupy the next four rankings i.e., 7^{th}, 8^{th}, 9^{th} and 10^{th} respectively. Prevention of diseases in general (11^{th}), obstetrics (12^{th}), surgery and therapeutics (13^{th}), etiology (14^{th}) and pathology (15^{th}) are the least ranked health information needs by the urban women.

From the calculated mean value it can be analysed that hospital and nursing home ($\bar{x}$=5.52), food ($\bar{x}$=5.52), diet regulation ($\bar{x}$=5.22), physical fitness ($\bar{x}$=5.21), personal hygiene ($\bar{x}$=5.13) are the top five ranked health information by the urban women. Nursing ($\bar{x}$=4.96), Public hygiene ($\bar{x}$=4.93), pharmaceutical ($\bar{x}$=4.79), birth control ($\bar{x}$=4.71), diseases ($\bar{x}$=4.59) are the next ranked health information needs. Prevention of diseases in general ($\bar{x}$=4.58), obstetrics ($\bar{x}$=4.49), surgery and therapeutics ($\bar{x}$=4.32), etiology ($\bar{x}$=4.01), pathology ($\bar{x}$=3.91) are the least ranked health information need by the urban women.

5.4. USE OF MASS MEDIA:

Table- 5.10: Listening to radio

Response	Number	Percentage
Yes	221	31.6
No	479	68.4
Total	**700**	**100.0**

In this study, it is found that radio is one of the oldest, popular and effective mass media used for providing health education. Data was collected on use of radio for getting health information. From table 5.10 reveals that majority of the urban women under study do not listen to radio programmes (68.4%, N=479). Only 31.6% (N=221) of women listen radio programmes. It can be interpreted that large majority of women do not listen to radio.

Table- 5.11: Frequency of listening to radio (N=221)

Frequency	Number	Percentage
Morning	128	57.9
Afternoon	34	15.3
Early evening	43	19.4
Late evening	52	23.5

A question was asked to women under study to know about the time of the day that they listen to radio more frequently. Majority of women prefer morning (57.9%, N=128) hours as the best time to listen to radio, followed by 23.5% of women who prefer to listen to radio programme in late evenings (N=52) and 19.4% prefer early evenings (N=43). It is observed that very few women listen to the radio during afternoon (15.3%, N=34) (Table 5.11).

Table- 5.12: Time spent in listening to radio programme (N=221)

Time spent	Number	Percentage
Less than 30 minutes	120	54.3
30 minutes to 1 hour	82	37.1
1 hour to 2 hour	19	8.6
Total	**221**	**100.0**

Women listen to radio depending upon their leisure time and convenience. It is found from table 5.12 that more than half (54.3%) of women spend less than thirty minutes in listening to the radio (N=120), followed by one third (37.1%, N=82) of women who spent 30 minutes to 1 hour to listen to radio programmes. Only 8.6% (N=19) of women spend more than one hour in listing to radio programme.

Table- 5.13: Listening to health related radio programme

Response	Number	Percentage
Yes	189	85.5
No	32	14.5
Total	**221**	**100.0**

Though 31.6% (N=221) of women under study listen to radio programmes, 85.5% (N=189) listen to health related programmes on radio. It can be said that health related radio programmes do not reach to the women under study (14.5%, N=32) (Table 5.13).

Table- 5.14: List of health related radio programmes listened to urban women (N=189)

Radio health programmes/ Preferred programmes	Number	Percentage
Radio Doctor	116	61.4
Arogyada Angala	38	20.1
Sakhi Saheli	69	36.5

From table 5.14, it can be analysed that a small percentage of women under study listen to health related radio programmes. 61.4% (N=116) of urban women under study listen to 'Radio Doctor' programme on radio. This programme has been most informative health programme to the women in getting health related information to support routine health diseases. 36.5% (N= 69) of women listen to 'Sakhi Saheli' health and women related programmes on radio and 'Arogyada Angala' health programme heard by very small percentage of women under study i.e. 20.1% (N=38).

Table- 5.15: Overall rating of health related radio programmes (N=189)

Radio programmes	Mean	Rank
News Stories	1.88	2
Talk shows	1.71	3
Special programmes on health care	2.18	1
Public service announcements	1.59	4
Advertising	1.47	5

Table 5.15 provides overall rating of health related radio programmes listened to by urban women. Various types of radio programmes have been listed and women were asked to rate the importance on a four point scale (1-None, 2-Little, 3-Some, 4-Greater extent) and the calculated mean is given in this table. Urban women under study listen to 'Special programmes on health care' ($\bar{x}$=2.18) on radio and it is ranked number one programme by the listeners and women listen programme on 'News stories' ($\bar{x}$=1.88), it is the second highest listenership programme among the women under study. 'Talk shows' ($\bar{x}$= 1.71), 'Public service announcements' ($\bar{x}$=1.59) and 'Advertising' ($\bar{x}$=1.47) which are rated as third, fourth and fifth radio programme listen by the urban women.

Table- 5.16: Radio as an health information supporting agency

Response	Number	Percentage
Yes	181	95.8
No	08	4.2
Total	**189**	**100.0**

From table 5.16 it can be analysed that nearly 95.8% (N=181) of women assertively say that radio as an information agency. It means that 4.2% (N=8) of the urban women feel that radio is not an information supporting agency.

Table- 5.17: Extent of usefulness of radio as information supporting agency (N=181)

Usefulness	Number	Percentage
Highly useful	52	28.7
Useful	106	58.6
Moderately useful	11	6.1
Moderately unuseful	11	6.1
Unuseful	0	0
Highly unuseful	1	0.5
Total	**181**	**100.0**

Mean value – 5.08

Women under study were asked to rate the usefulness of radio as an information support agency. From table 5.17, it is found that 58.5% (N=106) of women feel that radio programmes are useful information agencies and 28.7% (N=52) of women feel that radio programme are highly useful as far as usefulness is concern. Another 6.1% (N=11) of women rate radio programme is moderately useful and moderately unuseful. A very small percentage of women i.e 0.5% (N=1) of women rate radio programme is highly unuseful. Women who listen to radio, listen radio programmes in the morning hours for less than half an hour on heath related programme which they find quite useful.

Table- 5.18: Watching television

Watching television	Number	Percentage
Yes	639	91.3
No	61	8.7
Total	**700**	**100.0**

Women watch television for different purposes like entertainment, keeping up to date by watching news channels and getting information on various activities. From table 5.18, it is found that a larger proportion of urban women (91.3%, N=639) watch television and rest 8.7% (N=61) do not watch television programmes.

Table- 5.19: Time spent in watching television (N=639)

Time spent	Number	Percentage
Less than 30 mints	143	22.4
30 mints to 1 hour	209	32.7
1 hour to 2 hour	190	29.7
More than 2 hour	97	15.2
Total	**639**	**100.0**

When analyzed the table 5.19, to know the time spent in watching television in a day, it is found that nearly one third of women spend 30 mints to 1 hour to watch television (32.7%, N=209). It is also found that 29.7% (N=190) of them watch television 1 hour to 2 hour in a day and more than twenty two percent of the respondents watch television less than 30 mints (22.4%, N=143), only 15.2% (N=97) of them watch television more than two hour.

Table- 5.20: Frequency of watching Television (N=639)

Frequency	Number	Percentage
Morning	84	13.1
Afternoon	153	23.9
Early Evening	153	23.9
Late evening	331	51.8

Depending upon the convenience and availability of time, women watch television more frequently at evening hours of the day. Individuals who were employed prefer to watch television during late evening, while housewives and unemployed watch television more frequently during the afternoon and early evening. Most of urban women watch TV during late evening (51.8%, N=331). More than twenty three percent of women prefer to watch television during afternoon and early evening (23.9%, N=153) and 13.1% of women prefer to watch television in the morning (Table 5.20). A greater number of women watch television programme preferably in the late evening.

Table- 5.21: Awareness of women health programmes telecasted in Television

Awareness	Number	Percentage
Yes	428	67.0
No	211	33.0
Total	**639**	**100.0**

Women get health information by watching health programs on television, various health-related programmes. When analyzed the awareness of the respondents regarding women's health programmes telecasted by television, it is found that 67% (N=428) of the women do agree that they are aware of the women health programme telecasted by television. 33% (N=211) of women were unaware of health programme telecasted in television (Table 5.21).

Table- 5.22: Health related programmes watched by urban women (N=428)

Health programmes on television	Number	Percentage
DD Chandana		
Health	09	2.1
Hello Sakhi (live)	07	1.6
Arogya Bharatha	02	0.4
TV Doctor	03	0.7
Spon- RPT Health Programme	04	0.9
Beauty Tips	05	1.2
Yoga/Aerobics	04	0.9
Women's Programme	03	0.7
Chaluvina Chittara	16	3.7
TV9 Kannada		
Yoga Yoga	05	1.2
Ladies Club	25	5.8
Kalki Kannada		
Surabhi	04	0.9
Namaste Karunaadu (Mudra Yoga)	10	2.3
Namaste Karunaadu (Angaili Owshadhi)	08	1.8
Udaya TV		
Siri	19	4.4
Nati Vaidya	14	3.3
Udaya News		
Doctors	13	3.0
Public TV		
Nithya Sanjeevini	20	4.6

Yoga phala	14	3.3
Kasthuri TV		
Lifeline Live	04	0.9
Kasthuri Newz 24		
Doctors Dairy	09	2.1
Janasri News		
Health Center	10	2.3
Doctors Nature Clinic	08	1.8
Homeo Clinic	08	1.8
Clinic	19	4.4
Sanjeevini Clinic	13	3.0
Samaya 24 x 7		
Ladies Voice	15	3.5
Stri Samrajya	11	2.6
Suvarna News 24 x 7		
Dear Doctor	18	4.2
News BTV		
B Healthy	19	4.4
Workout/ Aerobics/Yogasutra	21	4.9
Naari Gallery	09	2.1
ETV News Kannada		
Hello Doctor	21	4.9
Raj News 24 x 7		
Herbal Medicine	10	2.3
Naturopathy Medicine	10	2.3
Sarala Jeevana		
Hello Doctor	20	4.6
Mane Maddu	16	3.7
Praja TV		
Sakhi Sukhi	17	3.9
Zee TV		
Yoga for you	10	2.3
Yogic Healing by Swami Ramdev	11	2.5
Aastha		
Yog Shivir	09	2.1
Ayurved Evam Jivan Darshan	09	2.1
Dhyan Yog	18	4.2
Khel Khel Me Yog	14	3.3
Seva Ganga	14	3.3
Sujok Therapy	11	2.5

Many programs are telecasted on television and providing information to the viewers. Apart from programs like movies, music, news, beauty, many programs related to health are telecasted on a regular basis. Health programs are in the form of interviews with doctors, advertisements related to health issues, specific health programs, about immunization or vaccination, programs on exercise, fitness, and yoga, about medicines and many other programs. Data on most preferred health programs on television for getting health information was compiled, and the television channels and health programmes are analysed.

Women under study were asked to mention the specific programmes that they watch on television. In DD Chandana channel telecast various health programme, in that urban women watch 3.7% (N=16) of 'chaluvina chittara' programme and 2.1% (N=09) of women watch 'health' programme, followed by 'hello sakhi (live) (1.6%, N=07)', 'beauty tips' (1.2%, N=05), 'yoga/aerobics' and 'spon – RPT health programme' (0.9%, N=04), 'TV doctor' and 'women's programme' (0.7%, N=03), 'arogya bharatha'(0.4%, N=02).

'Ladies club' programme telecast on TV9 Kannada with viewership of 5.8% (N=25) is the highly watched programme and 1.2% (N=05) of 'yoga yoga' programme watched by women. 'Namaste Karunaadu (Mudra Yoga)' telecast on 'Kalki Kannada' with viewership of 2.3% (N=10), 'Namaste Karunaadu (Angaili Owshadhi)' (1.8%, N=8) and 'Surabhi' (0.9%, N=4) programme watched by least number of urban women. 'Siri' programme telecast on 'Udaya TV' channel watched by below five percent (4.4%, N=19) of women and 3.3% (N=14) of women watch 'Nati Vaidya' programme.

'Doctors' programme telecast on 'Udaya News' (3%, N=13), 'Nithya Sanjeevini' (4.6%, N=20) and 'Yoga Phala' (3.3%, N=14) programme telecast on 'public TV'. 'Lifeline Live' telecast on 'Kasthuri TV' (0.9%, N=4), 'Doctors Dairy' telecast on 'Kasthuri Newz 24' (2.1%, N=9). 'Clinic' (4.4%, N=19), 'Sanjeevini Clinic' (3%, N=13), 'Health Center' (2.3%, N=10), 'Doctors Nature Clinic' and 'Homeo Clinic' telecast on 'Janasri News' (1.8%, N=8) are the other programmes watched by the urban women.

Urban women watch 3.5% (N=15) of 'Ladies Voice' programme and 2.6% (N=11) of women watch 'Stri Samraja' programme on 'Samaya 24x7'. 'Dear Doctor' programme telecast on 'Suvarna News 24x7' with viewership of 4.2% (N=18). 'Workout/Aerobics/Yogasutra' (4.9%, N=21), 'B Healthy' (4.4%, N=19) and 'Naari Gallary' (2.1%, N=9) Programme watched by women on 'News BTV'.

4.9% (N=21) of urban women prefer to watch 'Hello Doctor' telecast on 'ETV News Kannada' channel. 'Herbal Medicine' and 'Naturopathy Medicine' telecast on 'Raj News 24x7' with a viewership of 2.3% (N=10) of women. 'Sarala Jeevana' channel telecast health programme in that women watch 4.6% (N=20) of 'Hello Doctor' programme and 3.7% (N=16) of women watch 'Mane Maddu' programme, followed by 'Sakhi Sukhi' (3.9%, N=17) programme on 'Praja TV' and 'Yoga for you' (2.3%, N=10) and 'Yogic Healing by Swami Ramdev' (2.5%, N=11) programme on 'Zee TV'.

Aastha TV telecast various health programmes, urban women watch 4.2% (N=18) of 'Dhyan Yog' programme, followed by 'Khel Khel Me Yog', 'Seva Ganga' (3.3%, N=14), 'Sujok Therapy' (2.5%, N=11), 'Yog Shivir' and 'Ayurved Evam Jivan Darshan' (2.1%, N=9) programmes watched by women.

Table- 5.23: Ranking of Television Programmes on Health Issues (N=428)

Television Programmes	Mean	Rank
News Stories	2.02	2
Talk shows	1.99	3
Special programmes on health	2.18	1
Public service announcements	1.74	4
Advertising	1.70	5

Table 5.23 revealed ranking of television programmes on health issues. Special programmes on health ($\bar{x}$=2.18, 1st rank) were the most preferred program on television for getting health information, followed by news stories ($\bar{x}$=2.02, 2nd rank), talk shows ($\bar{x}$=1.99, 3rd rank), public service announcements ($\bar{x}$=1.74, 4th rank), advertising ($\bar{x}$=1.70, 5th rank) programmes were watched by urban women.

Table- 5.24: Television as an information supporting agency

Response	Number	Percentage
Yes	393	91.8
No	35	8.2
Total	**428**	**100.0**

The results of table 5.24 indicates that 91.8% (N=393) of urban women under study accept television as an information supporting agency. Further 8.2% (N=35) of urban women do not feel that television supports their information requirements.

Table- 5.25: Extent of usefulness of television as information supporting agency

(N=393)

Usefulness	Number	Percentage
Highly useful	99	25.2
Useful	208	52.9
Moderately useful	74	18.8
Moderately unuseful	12	3.1
Unuseful	0	0
Highly unuseful	0	0
Total	**393**	**100.0**

Mean Value – 5.0

Women under study were also asked to rate the usefulness of television as information supporting agency. From table 5.25, it is found that more than half (52.9%, N=208) of urban women rate television as a useful agency that supports their information requirements. 25.2% (N=99) of urban women rate television as highly useful for supporting their information requirements. 18.8% (N=74) of women rate television as moderately useful and only 3.1% (N=12) of women agreed that watching television was moderately unuseful in satisfying their health information needs.

Table- 5.26: Reading of newspapers

Response	Number	Percentage
Yes	398	56.9
No	302	43.1
Total	**700**	**100.0**

One of the objectives of the study is to identify whether urban women read newspapers. It is observed (table 5.26) that more than half percents of urban women i.e. 56.9% (N=398) read newspapers, Further a 43.1% (N=302) of women do not read newspapers.

Table- 5.27: Time spent in reading newspapers (N=398)

Time spent	Number	Percentage
Less than 30 minutes	232	58.3
30 mints to 1 hour	159	39.9
1 hour to 2 hour	07	1.8
More than 2 hour	0	0

It is found from table 5.27, 58.3% (N=232) of the women spend less than 30 minutes to read newspapers, followed by 39.9% (N=159) of urban women who spend 30 minutes to 1 hour and 1.8% (N=07) of urban women spend 1 hour to 2 hours in reading newspapers.

Table- 5.28: Preference of timing to read newspapers (N=398)

Preference	Number	Percentage
Morning	211	53.0
Afternoon	104	26.1
Early evening	56	14.0
Late evening	65	16.3

Urban women read newspapers preferably during morning hours. Usually, for some people, the day starts with reading newspapers with a morning cup of tea or coffee. For people who are free at home, prefer to read newspapers after completing their daily works in houses like housewives and unemployed. Students those who are studying in college prefer to read newspapers in college libraries. Among the readers of newspapers, the majority (53%, N=211) of them read newspapers during morning while, few read in an afternoon (26.1%, N=104), late evening (16.3%, N=65) and early evening (14%, N=56) (Table 5.28).

Table- 5.29: Newspapers read by urban women (N=398)

Newspapers	Number	Percentage
Kannada Prabha	77	19.3
The Hindu	15	3.8
Vijaya Karnataka	208	52.3
Vijaya Vani	178	44.7
Deccan Herald	09	2.3
Samyuktha Karnataka	56	14.1
Indian Express	20	5.0
Prajavani	167	41.9
Times of India	05	1.2
Udayavani	66	16.6
Local Newspapers	11	2.8

The newspapers are one of the most widely used print media to disseminate information among the general public. Newspapers are available in many languages, and individuals prefer the language in which they are comfortable. Urban women under study were asked to indicate the daily newspapers read by them. It is found from table 5.29 that 'Vijaya Karnataka' is the most popular newspaper read by 52.3% (N=208) of urban women under the study. Followed to this 44.7% (N=178) of women read to 'Vijaya Vani', 41.9% (N=167) of women read 'Prajavani', 19.3% (N=77) read 'Kannada Prabha', 16.6% (N=66) read 'Udayavani', 14.1% (N=56) read 'Samyukta Karnataka'. Thus it can be observed that women under study read newspapers in Kannada which is their mother tongue. English newspapers like, 'Indian Express' (5.0%, N=20), 'The Hindu' (3.8%, N=15), 'Deccan Herald' (2.3%, N=09) and 'Times of India' (1.2%, N=05) are read by very few people and 'Local newspapers' read by only 2.8% (N=11) of the urban women. More than half of women do read newspapers for less than half an hour in the morning. They prefer to read those newspapers published in Kannada language.

Table- 5.30: Women/health supplements of newspaper read by urban women (N=398)

Newspaper supplements	Number	Percentage
Vijayavani (Lalita)	164	41.2
Samyuktha Karnataka (SKcity)	42	10.5
Express Sunday (Magazine (Wellness)	03	0.7
Vijaya Karnataka (LavalaVK)	184	46.2
Udayavani (Avalu) (Saptahika Sampada)	40	10.0
Sunday Times (Life (Health)	01	0.2
Prajavani(Bhoomica)	71	17.8

From table 5.30 it can be interpreted that women/health supplement of newspapers read by the urban women. 46.2% (N=184) of urban women read 'Vijaya Karnataka (LavalaVK)' newspapers supplements, 41.2% (N=164) of women prefer to read 'Vijayavani (Lalita)' supplement and majority of the women prefer these two supplements are the most important and 17.8% (N=71) of the women prefer to read 'Prajavani(Bhoomica)' newspaper supplement. More than 10% of the urban women prefer to read 'Samyuktha Karnataka (SKcity)' (10.5%, N=42) and 'Udayavani (Avalu) (Saptahika sampada), (10%, N=40)'. Very less number of women prefer to read 'Express Sunday (Magazine (Wellness)' (0.7%, N=3) and 'Sunday Times (Life (Health))' (0.2%, N=1).

Table- 5.31: Usage of printed materials (N=398)

Printed material	Mean	Rank
Health magazines	2.08	2
Articles in newspapers	2.34	1
Medical books	1.42	5
Publicity materials from Health Organizations	1.54	3
Advertisements : Posters/Pamphlets	1.52	4

While reading newspapers, urban women read different sections of the newspapers like articles, news items, special editions, interviews, and advertisements. Sections of the newspaper were ranked based on the rating on a scale of 1 to 4. Article in newspapers ($\bar{x}$=2.34, 1st rank), health magazines ($\bar{x}$= 2.08, 2nd rank), publicity materials from health organizations ($\bar{x}$= 1.54, 3rd rank) were the top ranked sections read by the urban women. Advertisements: Posters/Pamphlets ($\bar{x}$=1.52, 4th rank) and

medical books ($\bar{x}$= 1.42, N=5) are the next ranked sections read by the urban women (Table 5.31).

Table- 5.32: Newspapers as an information supporting agency

Response	Number	Percentage
Yes	377	94.7
No	21	5.3
Total	**398**	**100.0**

The study was made to know whether newspapers support the health information requirements of the urban women. Form table 5.32, it is found that more than ninety four percent of the urban women under study i.e. 94.7% (N=377) of them feel that newspapers support their health information requirements. Further, it is found that 5.3% (N=21) of urban women feel that newspapers do not support their health information requirements.

Table- 5.33: Usefulness of newspaper as information supporting agency (N=377)

Usefulness	Number	Percentage
Highly useful	135	35.8
Useful	172	45.6
Moderately useful	68	18.0
Moderately unuseful	0	0
Unuseful	2	0.5
Highly unuseful	0	0
Total	**377**	**100.0**

Mean value – 5.16

The data of usefulness of newspapers as supporting agency is tabulated in table 5.33. The results reveal that 45.6% (N=172) of women feel that newspaper is a useful information supporting agency and 35.8% (N=135) of women rate newspapers are highly useful in supporting their information requirements. It is also found that very small percentage that is 18% (N=68) of urban women rate newspapers are moderately useful agencies to supports their information requirements. Another only 0.5% (N=2) of women feel that it is an unuseful agency that can't caters their information requirements. Women who read newspapers find health related information quite useful.

Table- 5.34: Magazines/ Periodicals read by urban women

Response	Number	Percentage
Yes	279	39.9
No	421	60.1
Total	**700**	**100.0**

A question was asked to know whether urban women under study read periodicals. Form table 5.34, it is found that more than sixty percent of the women (60.1%, N=421) do not read women related magazines/periodicals. 39.9% (N=279) of urban women read women related periodicals.

Table- 5.35: List of Magazines/ Periodicals read by urban women (N=279)

Magazine/ Periodicals	Number	Percentage
Sudha	16	5.7
Grihshobha	28	10.0
Karmaveera	11	3.9
Women's Era	15	5.4
Priyanka	11	3.9
Vogue	03	1.1
Reader's Digest	08	2.9
Chutuka	03	1.1
Taranga	32	11.4
Mayura	16	5.7
Cosmopolitan	03	1.1
Femina	19	6.8
The Week	11	3.9
Sakhi	18	6.4
Manasa	09	3.2
Navaraga Sangama	01	0.3
Tushar	19	6.8
Debonair	03	1.1
Frontline	05	1.8
Roopatara	14	5.0
Nisarga	03	1.1
Drishti	03	1.1
Kasturi	08	2.9
Grihlakshmi	08	2.9
Society	02	0.7
India Today	03	1.1
New woman	05	1.8
Butti	01	0.3
Wisdom	01	0.3

Women under study were asked to identify periodicals that they read regularly 11.4% (N=32) of urban women read 'Taranga', 10% (N=28) of women read 'Grihshobha' and 'Femina', 'Tushar' is read by 6.8% (N=19) of women and 6.4% (N=18) of women read 'Sakhi' periodicals. These are the top five periodicals read by women under study. 'Sudha', 'Mayura' (5.7%, N=16), 'Women's Era' (5.4%, N=15) 'Roopatara' (5%, N=14), 'Karmaveera', 'Priyanka', 'The Week' (3.9%, N=11), 'Manasa' (3.2%, N=09), 'Kathuri', 'Grihlakshmi' and 'Reader's Digest' (2.9%, N=08) are read by the urban women. 'Frontline' and 'New women' (1.8%, N=05), 'Vogue', 'Chutuka', 'Cosmopolitan', 'Debonair', 'Nisarga', 'Drishti' and 'India Today' are read by only 1.1% (N=3) of women. 'Society' (0.7%, N=2), 'Butti', 'Wisdom'&'Navaraga Sangama' (0.3%,N=1) are read by very few number of women.

Table- 5.36: List of health related magazines/periodicals read by urban women (N=279)

Health magazines	Mean	Rank
Health and Nutrition	1.73	2
Prevention	1.31	7
Health Plus	1.43	6
Vydyaloka	1.22	13
Sanjeevini	1.56	4
Women's Health	2.07	1
Fitness	1.62	3
Chandrodaya	1.17	14
Health Café	1.29	8
Arogyavani	1.50	5
Yoga	1.18	14
HEAL	1.24	11
Arogya Sandesh	1.29	8
Health	1.16	16
Swasthya Aur Jeevan	1.24	11
Yog Sandesh	1.27	10
Health Vision	1.03	17

Data on the reading of health related magazines for getting health information was collected from the urban women. There are several magazines exclusively devoted to health in all languages. From table 5.36, it is found that 'Women's Health' ($\bar{x}$=2.07, 1st rank), 'Health and Nutrition' ($\bar{x}$=1.73, 2nd rank), 'Fitness' ($\bar{x}$=1.62, 3rd rank), 'Sanjeevini' ($\bar{x}$=1.56, 4th rank), 'Arogyavani' ($\bar{x}$=1.50, 5th rank) are the top five

magazines read by urban women. 'Health Plus' ($\bar{x}$=1.43, 6th rank), 'Prevention' ($\bar{x}$=1.31, 7th rank), 'Health cafe', 'Arogya Sandesh' ($\bar{x}$=1.29, 8th rank), 'Yog Sandesh' ($\bar{x}$=1.27, 10th rank) are the next preferred magazines by the women. 'Swasthya Aur Jeevan', 'HEAL' ($\bar{x}$= 1.24, 11th rank), 'Vydyaloka' ($\bar{x}$= 1.22, 13th rank), 'Chandrodaya', 'Yoga' ($\bar{x}$=1.17, 14th rank), 'Health' ($\bar{x}$=1.16, 16th rank) and 'Health Vision' (1.03, 17th rank) are the least ranked health magazines read by the urban women.

Table- 5.37: Magazines/periodicals as information supporting agencies

Response	Number	Percentage
Yes	260	93.2
No	19	6.8
Total	**279**	**100.0**

From table 5.37, it is found that 93.2% (N=260) of urban women feel that magazines/periodicals support their health information requirements. 6.8% (N=19) of women feel that periodicals/magazines do not support their information requirements.

Table- 5.38: Extent of usefulness of magazines/periodicals as information supporting agency (N=260)

Usefulness	Number	Percentage
Highly useful	49	18.8
Useful	172	66.2
Moderately useful	30	11.5
Moderately unuseful	7	2.7
Unuseful	2	0.8
Highly unuseful	0	0
Total	**260**	**100.0**

Mean Value- 4.99

It can be analysed from table 5.38 that small percentage of women i.e. 66.2% (N=172) rate the usefulness of magazines/periodicals as useful in supporting their information requirements. 18.8% (N=49) of women rate periodicals for their usefulness as highly useful and another 11.5% (N=30) rate the periodicals as moderately useful. 2.7% (N=7) of women rate the magazines are moderately unuseful and 0.8% (N=2) of women rate unuseful of magazines/periodicals as information supporting agency. Women who read magazines find information quite useful.

Table- 5.39: Health related books read by urban women

Response	Number	Percentage
Yes	268	38.3
No	432	61.7
Total	**700**	**100.0**

A question was asked to know whether women under study read health related books other than newspapers and magazines. From table 5.39, it is found that 61.7% (N=432) of urban women do not read such books. Women health related books are read by 38.3% (N=268) of urban women.

Table- 5.40: Health related books as information supporting agency

Response	Number	Percentage
Yes	257	95.9
No	11	4.1
Total	**268**	**100.0**

Table 5.40, indicates that 95.9% (N=257) of urban women feel that health related books supports their information requirements. 4.1% (N=11) of women feel that women health related books does not support their information requirements.

Table- 5.41: Extent of usefulness of women health related books as information supporting agency (N=257)

Usefulness	Number	Percentage
Highly Useful	93	36.2
Useful	14	5.4
Moderately useful	145	56.4
Moderately unuseful	4	1.5
Unuseful	0	0
Highly Unuseful	1	0.4
Total	**257**	**100.0**

Mean Value- 4.75

From table 5.41, it is found that hardly 56.4% (N=145) of urban women rate health related books as useful for their usefulness and 36.2% (N=93) of women rate health related books are highly useful. Few percent of women like 5.4% (N=14) rate women health related books has moderately useful. Hardly 1.5% (N=4) rate women health related books as moderately unuseful and only 0.4% (N=1) of women rate that it is

highly unuseful. Large number of women does not read health related books. Those who read health related books consider it as moderately useful information supporting agency.

Table- 5.42: Consultation of human resources to collect health information

Consultancy	Number	Percentage
Yes	391	55.9
No	309	44.1
Total	**700**	**100.0**

One of the objectives of the study is to know whether human resources are used by women under study for supporting their health information requirements. Form table 5.42, it is found that a majority of women i.e. 55.9% (N=391), consult human resources to collect health information. 44.1% (N=309) of urban women do not consult any human resources to collect health information.

Table- 5.43: Categories of human resources consulted (N=391)

Human resources	Number	Percentage
Concerned professionals	79	20.2
Nurses	120	30.7
Family Members	253	64.7
Doctors	302	77.2
Traditional Healer	19	4.8
Govt. Information Officers	17	4.3
Taluk Health Officer	41	10.5
Social Workers	72	18.4
Friends/Neighbours	187	47.8
Librarian	34	8.7
Health workers	51	13.0
Primary Healthcare Workers	28	7.2
District Health Officer	22	5.6
Medical Officers of the Primary Health Centers	41	10.5

From table 5.43, it is found that urban women under study consult various human resources to support their health information requirements. 77.2% (N=302) of women consult doctors while 64.7% (N=253) consult family members and 47.8% (N=187) consult friends/neighbours for supporting their health information requirements. Doctors, family members and friends/neighbours are the top three most preferred

human resources by urban women for supporting their health information requirements.

More than 30% of urban women consult nurses (30.7%, N=120), 20.2% (N=79) of women consult concerned professionals and 18.4% (N=72) of women consult social workers for their health information requirements, followed by health workers (13%, N=51), medical officers of the primary health centers, taluk health officer (10.5%, N=41), librarian (8.7%, N=34), primary healthcare workers (7.2%, N=28), district health officer (5.6%, N=22), traditional healter (4.8%, N=19), Govt. information officers (4.3%, N=17) are the least consulted human resources by the urban women for their health information requirement. Majority of women consult human resources to obtain health information from doctors, family members, friends and neighbours.

Table- 5.44: Human resources as health information supporting agency

Response	Number	Percentage
Yes	345	88.2
No	46	11.8
Total	**391**	**100.0**

From table 5.44, it is found that 88.2% (N=345) of urban women feel that human resources support their health information requirements. 11.8% (N=46) of women feel that human sources do not support their health information requirements.

Table- 5.45: Usefulness of human resources as information supporting agency (N=345)

Usefulness	Number	Percentage
Highly useful	75	21.7
Useful	175	50.7
Moderately useful	86	25.0
Moderately unuseful	7	2.0
Unuseful	1	0.3
Highly unuseful	1	0.3
Total	**345**	**100.0**

Mean Value- 4.90

Data on usefulness of human sources in supporting their health information requirements is tabulated in table 5.45. It is found that 50.7% (N=175) of urban women rate human sources as useful in supporting their health information requirements. 24.9% of women (N=86) rate human sources for their usefulness as moderately useful. While a very small percentage of women that is 21.7% (N=75) rate them as highly useful. Only 2% (N=7) of women rate that human resources are moderately unuseful and 0.3% of women rate that unuseful and highly unusefulness of human resource in supporting their health information requirements. Urban women feel human resources are quite useful.

Table- 5.46: Consultation of institutional resources to collect health information

Consultation	Number	Percentage
Yes	289	41.3
No	411	58.7
Total	**700**	**100.0**

One of the objectives of the study is to know whether urban women under study consult institutional sources to collect health information. It is found from table 5.46 that more than forty percent of the urban women under study that is 41.3% (N=289) consult institutional sources to collect health information. 58.7% (N=411) of women do not consult any institutional resources for their health information requirements.

Table- 5.47: Institutional resources consulted (N=289)

Institutional resources	Number	Percentage
Government Organisation	68	23.5
Hospitals	218	75.4
Libraries	25	8.6
Women organization	15	5.2
Urban Health Center	10	3.5
Community Health Centers (CHCs)	08	2.8
Non Government Organization	05	1.7
Nature care centers	12	4.1
Urban Primary Health Centers	04	1.4
District Surveillance Unit	02	0.7
District AIDS Prevention and Control Unit	04	1.4
Mobile Health Clinic	06	2.1

From table 5.47, it is found that urban women consult different institutional resources for supporting their health information requirements. More than 75.4% (N=218) of urban women approach hospitals, 23.5% (N=68) consult Government organisation and 8.6% (N=25) of urban women consult libraries for their health information requirements. 5.2% of women consult women organization (N=15) and 4.1% of women consult nature care centers (N=12) for supporting their health information requirements.

Urban health center (3.5%, N=10), community health centers (CHCs) (2.8%, N=8), mobile health clinic (2.1%, N=6), non government organization (1.7%, N=5), urban primary health centers and district AIDS prevention and control unit (1.4%, N=4) and district surveillance unit (0.7%, N=2) are the least consult institutional resources for supporting their health information requirement. Institutional resources are not consulted by the majority of the women with few depending on hospitals. Library is the least preferred institution consulted institutional resources by the urban women.

Table- 5.48: Use of library

Use of library	Number	Percentage
Yes	109	15.6
No	591	84.4
Total	**700**	**100.0**

From table 5.48, it can be analysed that a greater majority of urban women (84.4%, N= 591) do not use library. It can further be analysed that a very small proportion of women (15.6%, N= 109) use library.

Table- 5.49: Library membership among urban women (N=109)

Library membership	Number	Percentage
Yes	67	61.5
No	42	38.5
Total	**109**	**100.0**

From table 5.49, it can be analysed that only 61.5% (N=67) of urban women have become members of the library.

Table- 5.50: Type of libraries preferred by the urban women to visit (N=109)

Type of libraries	Number	Percentage
Public library	21	19.3
College Library	35	32.1
Special Library	0	0
School Library	23	21.1
University Library	30	27.5

From table 5.50, it can be analysed that 32.1% (N=35) of the respondents preferred to visit college library, 27.5% (N=30) of the respondents preferred university library, 21.1% (N=23) of women preferred to visit school library and hardly 19.3% (N=21) of the urban women preferred public library for gathering information.

Table- 5.51: Frequency of visit to library (N=109)

Frequency	Number	Percentage
Daily	06	5.5
Once a week	08	7.3
Monthly	12	11.0
Yearly	15	13.8
Rarely	68	62.4

From table 5.51, frequency of visit to library can be observed. Among them only 62.4% (N=68) of urban women visit library rarely. 13.8% (N=15) of women visit library yearly. 11% (N=12) of women visit library monthly and hardly 7.3% (N=08) of women visit the library once a week. Only 5.5% (N=06) of urban women visit library daily.

Table- 5.52: Reasons for not visiting the library (N=591)

Reasons	Number	Percentage
No library available	5	0.8
Do not know reading and writing	16	2.7
Information available on fingertips	56	9.5
Not interested	205	34.7
Lack of time	309	52.3

Table 5.52 provides the reasons for not visiting the library by the respondents. It can be found that 52.3% (N=309) of the respondents quoted lack of time is the reasons for not visiting the library, not interested (34.7%, N=205), information available on fingertips (9.5%, N=56), do not know reading and writing (2.7%, N=16) and no library facilities available (0.8%, N=5) are quoted as the reasons given by them for not using library. A very small number of women who are members of the libraries use library and visit libraries quite rarely. Not interest and lack of time are the major reason for not visiting the library.

Table- 5.53: Subjects preferred in obtaining information in the libraries (N=109)

Subjects preferred	Number	Percentage
Education	41	37.6
Social Welfare	06	5.5
Agriculture	16	14.7
National	20	18.3
Science	07	6.4
Art & Trends	10	9.2
Law	12	11.0
Employment News	31	28.4
Economic/Finance	15	13.8
International	03	2.8
Cinema	02	1.8
Advertisement	08	7.3
Health	14	12.8
Sports	01	0.9
Current Affaires	33	30.3
Local News	09	8.3
Entertainment	27	24.8
Government Programs	19	17.4

A question was asked to urban women to know the subjects preferred in obtaining information in the libraries. From table 5.53, it can be observed that 37.6% (N=41) of women prefer to read information on education in libraries and 30.3% (N=33) of women preferred current affaire information in library, followed by employment news (28.4%, N=31), entertainment (24.8%, N=27), national (18.3%, N=20), Government programs (17.4%, N=19), agriculture (14.7%, N=16), economic/ finance (13.8%, N=15), health (12.8%, N=14), law (11%, N=12), arts and trends (9.2%, N=10), local

news (8.3%, N=09), advertisement (7.3%, N=08), science (6.4%, N=07), social welfare (5.5%, N=06), international (2.8%, N=03), cinema (1.8%, N=2) and sports (0.9%, N=01) are the other preferred subjects by the urban women in the libraries.

Table- 5.54: Institutional resources as information supporting agency

Response	Number	Percentage
Yes	226	78.2
No	63	21.8
Total	**289**	**100.0**

From table 5.54 it is found that 78.2% (N=226) of urban women feel that institutional resources support their information requirements. 21.8% (N=63) of women feel that institutional resources do not support their information requirements.

Table- 5.55: Usefulness of institutional resources as information supporting agency (N=226)

Usefulness	Number	Percentage
Highly useful	38	16.8
Useful	127	56.2
Moderately useful	53	23.4
Moderately unuseful	7	3.1
Unuseful	0	0
Highly unuseful	1	0.4
Total	**226**	**100.0**

Mean Value- 4.85

The data of usefulness of institutional resources as an information supporting agency is tabulated and it is found from table 5.55 that institutional resources are rated useful by 56.2% (N=127) of urban women. While 23.4% (N=53) rated institutional resources as moderately useful, only 16.8% (N=38) rated institutional resources are highly useful, a very few women (3.1%, N=7) rated institutional resources as moderately unuseful and 0.4% (N=1) rated these are highly unuseful. Women who consult institutional resources for health related information find it quite useful.

Table- 5.56: Use of Internet and E-resources

Use	Number	Percentage
Yes	318	45.4
No	382	54.6
Total	**700**	**100.0**

One of the objectives of the study is to know whether urban women use internet and e-resources for supporting their health information requirements. From table 5.56, it is noticed that 54.6% (N=382) of urban women do not consult internet and e-resources for their health information requirement. Further internet and e-resources are used by 45.4% (N=318) of women.

Table- 5.57: Collecting of health related information through Internet and E-resources

Response	Number	Percentage
Yes	194	61.0
No	124	39.0
Total	**318**	**100.0**

From table 5.57, it is found that 61% (N=194) of urban women collect health related information through internet and e-resources. 39% (N=124) of women do not collect health related information through internet and e-resources.

Table- 5.58: Preferred areas of health information searched on Internet and E-resources (N=194)

Preferred Health Information	Number	Percentage
General health issues	48	24.7
New Disease	3	1.5
Cancer	4	2.1
Diseases	5	2.6
Women health issues	24	12.4
Yoga Fitness	2	1.0
Nutrition	5	2.6
Periods	6	3.1
Pregnancy	4	2.1
Beauty tips	15	7.7
Diet/ food	35	18.0
Hair fall	4	2.1
Health education	6	3.1
Fitness	20	10.3
Ayurvedic	5	2.6
Govt health plans	4	2.1
Hospital Information	4	2.1

A question was asked to urban women to prefer areas of health information searched on internet and e-resources. From table 5.58 it can be found that very few women collect information through internet on general health issues (24.7%, N=48), diet/food (18%, N=35), women health issues (12.4%, N=24) and fitness (10.3%, N=20) this is mainly preferred to gather health information on internet and e-resources. Beauty tips (7.7%, N=15), periods and health education (3.1%, N=6), diseases, nutrition and ayurvedic (2.6%, N=5), cancer, pregnancy, hair fall, Govt. health plans and hospital information (2.1%, N=4), new disease (1.5%, N=3) and yoga fitness (1.0%, N=2) are the other preferred areas of health information searched on internet and e-resources.

Table- 5.59: Internet and E-resources as health information supporting agency

Response	Number	Percentage
Yes	184	94.8
No	10	5.2
Total	**194**	**100.0**

From table 5.59, it is found that 94.8% of women (N=184) claim that Internet and E-resources support their health information requirements. Further among 5.2% (N=10) of urban women who use internet claim that it's not supports their health information requirements.

Table- 5.60: Usefulness of Internet and E-resources as health information supporting agency (N=184)

Usefulness	Number	Percentage
Highly useful	85	46.1
Useful	94	51.2
Moderately useful	4	2.2
Moderately unuseful	1	0.5
Unuseful	0	0
Highly unuseful	0	0
Total	**184**	**100.0**

Mean Value- 5.4

It can be analysed that 51.2% (N=94) of women rate internet and e-resources as useful, while 46.1% (N=85) rate it as highly useful, very less number of women i.e. 2.2% (N=4) rate internet and e-resources are moderately useful and only 0.5% (N=1) of women rate moderately unusefulness of internet and e-resources as health information supporting agency (Table 5.60). Internet and e-resources are considered most useful information agency for more than two fourth of women. Among them a significant number of women collect health related information on general health issues. Women who are using internet and e-resources are finding it as a useful health information supporting agency.

Table- 5.61: Reasons for not using Internet and E-resources (N=382)

Reasons	Number	Percentage
Don't have smart phone	7	1.8
Don't know how to get health information	5	1.3
Don't know health website	4	1.0
Don't know how to access health information	4	1.0
Health information search problem	1	0.3
Internet problem	4	1.0
Not get exact health information	6	1.6
Related women Alth Not satisfied with the information	2	0.5
Slow internet facility	2	0.5

Table 5.61 provides the reasons for not using internet and e-resources by the respondents. It can be found that (1.8%, N=7) don't have smart phone do not get exact health information (1.6%, N=6), don't know how to get health information (1.3%, N=5), don't know health website, don't know how to access health information and internet problem (1.0%, N=4), not satisfied with the information and slow internet facility (0.5%, N=2) were quoted as the reasons given by the urban women for not using internet and e-resources.

5.5 KNOWLEDGE OF UNDERSTANDING HEALTH PROBLEM:

Table- 5.62: Knowledge of understanding health problems

Knowledge	Number	Percentage
Yes	104	14.9
No	596	85.1
Total	**700**	**100.0**

Table 5.62 revels that, majority of the women do not have knowledge of understanding their health problems (85.1%, N=596) and only 14.9% of women have knowledge of understanding their health problem (N=104).

Table- 5.63: Health problems understood by the urban women (N=104)

Health problem	Number	Percentage
Allergy	7	6.7
Asthma	2	1.9
Back pain	4	3.8
General health problem	4	3.8
BP	3	2.9
Cough Cold fever	11	10.6
Headache	23	22.1
Food Poisoning	1	0.9
Kidney problem	3	2.9
Obesity	9	8.6
Physical stress	3	2.9
Skin problem	3	2.9
Stomach pain	5	4.8
Stress and tension	12	11.5
Sugar	5	4.8
Tyroid	3	2.9
Weakness	6	5.8

Table 5.63 depicts that the health problems understood by the urban women. Very less number of urban women understand general health issues like Headache (22.1%, N=23), Stress and tension (11.5%, N=12) and Cough, cold, fever (10.6%, N=11), followed by Obesity (8.6%, N=9), Allergy (6.7%, N=7), Weakness (5.8%, N=6), Stomach pain and Sugar (4.8%, N=5), Back pain and General health problem (3.8%, N=4), BP, Kidney problem, Physical stress, Skin problem and Tyroid (2.9%, N=3), Asthma (1.9%, N=2) and Food poisoning (0.9%, N=1) are the general health issues understand by the least number of urban women. Large numbers of women claim that they can't conceptualize health problem other than general ones like headache, stress, tension, cough, cold and fever.

Table- 5.64: Understanding of the treatment suggested by the doctor

Response	Number	Percentage
Yes	304	43.4
No	396	56.6
Total	**700**	**100.0**

Study describes that, more than half of the women don't understanding of the treatment suggested by the doctor (56.6%, N=396). On the other hand 43.4% urban women understand of the treatment suggested by the doctor (N=304) (Table - 5.64). Surprising large number of women do not understand the treatment suggested by the doctor.

Table- 5.65: Remembering the name of the medicine taking

Response	Number	Percentage
Yes	254	36.3
No	446	63.7
Total	**700**	**100.0**

It can be seen that, more than 63% of the women respondents don't remembering the name of the medicine taking (N=446). On the other hand 36.3% urban women remembering the name of the medicine prescribed by the doctor (N=254) (Table-5.65). Large numbers of women don't remember the name of the medicine.

Table- 5.66: Interested to know health problem

Response	Number	Percentage
Yes	345	49.3
No	355	50.7
Total	**700**	**100.0**

Table 5.66 indicates that, 49.3% women respondents reveal that, they interested to know their health problem (N=345), whereas 50.7% women respondents do not interested to know their health problem (N=355).

Table- 5.67: Understanding health problem from different aspects (N=345)

Response	Number	Percentage
Doctor	319	92.4
Oral explanation by similar patient	53	15.4
Reading	58	16.8
Neighbors	30	8.7
Seeing	32	9.3
Family members	74	21.4

It can be analysed from above table 5.67 that, nearly 93% of the women respondents understanding their health problem from concern doctor (92.4%, N=319). However, 21.4% of urban women understanding health problem from family members (N=74), 16.8% from reading (N=58), 15.4% from oral explanation by similar patients (N=53), 6.3% from seeing (N=32) and 8.7% (N=30) women respondents understanding their health problem from Neighbors.

5.6 AWARENESS OF GOVERNMENT PROGRAMMES:

Table- 5.68: Awareness of Government programmes

Response	Number	Percentage
Yes	456	65.1
No	244	34.9
Total	**700**	**100.0**

Women under study were asked whether they are aware of the programmes of the Government and it is found from table 5.68 that 65.1% (N=456) of the women are aware of at least one programme of the Government. Surprisingly one third of the women (34.9%, N=244) are unaware of the Government programmes.

Table- 5.69: Awareness of Government programmes related to health (N=456)

Government programmes	Number	Percentage
Arogya Bhagya	316	69.3
Mahila Bhagya	296	64.9
Arogya Kavacha	269	59.0
Bhagyalakshmi	347	76.1
Thayi Bhagya	303	66.4
Janani Suraksha Yojana	147	32.2
Balika Samriddhi Yojana	84	18.4
Kishori Shakti Yojana	105	23.0
Prasooti Araike	103	22.6
Madilu	163	35.7
Urban Streeshakti Scheme	53	11.6
Swadhar	59	12.9
Yeshasvini Cooperative Farmers Health Care Scheme	230	50.4
Swawlamban	41	9.0
National Maternity Benefits Scheme	49	10.7
Rural Health component of the Minimum Needs Programme	32	7.0
Medical Development programme and Hospital Pharmacy Programme	27	5.9
National 'AIDS' Control Programme	82	17.9
Reproductive Child Health	49	10.7
National Tuberculosis Control Programme	37	8.1
National Vector Borne Disease Control Programme	22	4.8
Health Education and Training Programme	48	10.5
Nutrition Programme	56	12.3
Amruta Yojane	52	11.4
Swarna Jayanti Shahari Rozgar Yojana	66	14.5
Santhwana	95	20.8

Women were asked to show their acquaintances with various Government programmes and it is found from the table 5.69 that the urban women are aware of different government schemes. 76.1% (N=347) of urban women are aware of 'Bhagyalakshmi', 69.3% (N=316) of women are aware of 'Arogya bhagya', 66.4%, (N=303) of women are aware of 'Thayi Bhagya', 64.9% (N=296) of women are aware of 'Mahila Bhagya', 59% (N=269) of women are aware of 'Arogya Kavacha' programmes, 50.4% (N=230) of women are aware of 'Yeshasvini Cooperative Farmers Health Care Scheme'.

Another 35.7% (N=163) are aware of existence of 'Madilu' and its functioning, 32.2% (N=147) are aware of the activities of 'Janani Suraksha Yojana', another 23% (N=105) of women are aware of 'Kishori Shakti Yojana'. It is also found that 22.6% (N=103) of women are aware of 'Prasooti Araike', 20.8% (N=95) of women know what 'Santhwana' is, 18.4% (N=84) of women are aware of the existence of 'Balika Samriddhi Yojana'. 17.9% (N=82) of women are aware of 'National 'AIDS' Control Programme', 14.5% (N=66) of women are aware of 'Swarna Jayanti Shahari Rozgar Yojana', 12.9% (N=59) of women are aware of 'Swadhar', 12.3% (N=56) of women are also aware of programmes of 'Nutrition Programme' and the 'Urban Streeshakti Scheme' (11.6%, N=53).

Other programmes like 'Amruta Yojane (11.4%, N=52), 'National Maternity Benefits Scheme and Reproductive Child Health' (10.7%, N=49), 'Health Education and Training Programme' (10.5%, N=48), 'Swawlamban' (9%, N=41), 'National Tuberculosis Control Programme' (8.1%, N=37), 'Rural Health component of the Minimum Needs Programme' (7%, N=32), 'Medical Development programme and Hospital Pharmacy Programme' (5.9%, N=27), 'National Vector Borne Disease Control Programme' (4.8%, N=22), etc are know by very few women. Large numbers of women under study are aware of Government programme on health. Particularly Bhagyalakshmi, Arogya Bhagya, Thayi Bhagya and Mahila Bhagya.

Table- 5.70: Sources of information used to know the Government programmes (N=456)

Sources of information	Number	Percentage
Radio	148	32.4
Friends	209	45.8
Neighbours	137	30.0
Concerned Staff	28	6.1
Television	349	76.5
Government office	59	12.9
Family Members	184	40.3
Social workers	70	15.3
Newspapers	264	57.9
Libraries	18	3.9
Associations/Institutions	29	6.3
Teachers	117	25.7

A question was asked to know the sources of information used by urban women who made them aware of the Government programmes. 76.5% (N=349) of women claimed that they were able to know about Government programmes through television, 57.9% (N=264) of women aware of Government programmes through newspapers. 45.8% (N=209) of women also claimed that they were aware of Government programmes through their friends.

Television, newspapers and friends are the three most preferred sources of information to know the Government programmes. 40.3% (N=184) of women also claimed family members are sources of information while nearly 32.4% (N=148) of women identify radio as sources of information. Near one third of women identify neighbours (30%, N=137) used as sources of information. 25.7% (N=117) of women became aware of Government programmes through teachers. 15.3% (N=70) came to know about Government programmes through social workers. 3.9% (N=18) became aware of Government programmes through libraries, 12.9% (N=59) of women became aware of Government programmes through Government office. 6.3% (N=29) claim associations/institutions as sources of information. 6.1% (N=28) of women also claim concerned staff as the source of information.

Among the mass media is the major source of information about Government programmes. This clearly indicates that institutions have failed in their role to reach urban women.

Table- 5.71: Usefulness of health development programmes of the Government (N=456)

Usefulness	Number	Percentage
Highly useful	89	19.5
Useful	224	49.1
Moderately useful	90	19.8
Moderately unuseful	9	2.0
Unuseful	26	5.7
Highly unuseful	18	3.9
Total	**456**	**100.0**

Mean Value- 4.58

A question was asked to know that to what extent health information available on Government programmes to urban women is useful and the data is tabulated. From table 5.71 it is found that nearly one third of urban women i.e. 49.1% (N=224) claim that available information on Government programmes is useful for them. 19.7% (N=90) of women rate usefulness of available information as moderately useful, followed by 19.5% (N=89) highly useful, 5.7% (N=26) unuseful, 3.9% (N=18) highly unuseful and only 2% (N=9) moderately unuseful rated by the urban women. Television is the cheapest source for the women to know Government programmes they feel that programme are quite useful.

Table- 5.72: Beneficiaries of health programmes of the Government

Response	Number	Percentage
Yes	44	6.3
No	656	93.7
Total	**700**	**100.0**

Table 5.72, can be analysed that 6.3% (N=44) of the women are beneficiaries of health programmes of the Government, whereas the remaining 93.7% (N=656) are not benefited the health programmes of the Government.

Table- 5.73: List of benefited health schemes related to urban women (N=44)

Schemes	Number	Percentage
Arogyabhagya	12	27.3
Bhagyalaxmi	5	11.4
Madilu	4	9.1
National health	2	4.5
Santvana	1	2.3
Thayibhagya	2	4.5
Vidyashree	2	4.5
Yashaswini	16	36.4

A question was asked to those urban women who claim that they where benefited by Government schemes to list the schemes under which they where benefited. From table 5.73 it is found that very less number of women are benefited health schemes i.e. 36.4% (N=16) of urban women are benefited through 'Yeshaswini' and 27.3% (N=12) are benefited under 'Arogyabhagya'. Very few women are benefited under other schemes i.e. 'Bhagyalaxmi' (11.4%, N=5), 'Madilu' (9.1%, N=4), 'National health, Thayibhagya and Vidyashree' (4.5%, N=2) and 'Santvana' (2.3%, N=1).

Table- 5.74: Problems encountered in obtaining health information for urban women (N=700)

Problems	Number	Percentage
We don't know how/ whom to approach	113	16.1
Distance of facilities	99	14.1
No one accompanying me to hospital	50	7.1
No female health worker/No lady worker	72	10.3
Response of the doctor is rude	51	7.3
Services too expensive/Too costly	106	15.1
Don't know what services offered	120	17.1
There is no time	106	15.1
Don't know Governmental Schemes/Programmes	87	12.4
Public transport not available	60	8.6
Health centers are too far	56	8.0
Timing does not match	73	10.4
Cannot communicate properly	49	7.0
Response of the health worker is rude	40	5.7
Poor service offered	72	10.3
I don't have the need yet	95	13.6

Table 5.74 shows difficulty faced by urban women in accessing health care facilities. 17.1% (N=120) of the women opine that they don't know what services offered, 16.1% (N=113) find that they don't know how and whom to approach for their health problem, 15.1% (N=106) of the respondents opinion that the services provided in the hospital is too expensive and there is no time to women to get health information.

14.1% (N=99) opine that distance of facilities is the one of the problem, 13.6% (N=95) are of the opinion that they don't have the need yet, 12.4% (N=87) of women feel that they don't know Governmental schemes/programmes, 10.4% (N=73) feel that timing does not match and 10.3% (N=72) feel that in hospitals offered poor service and some hospitals have no female health worker/lady doctor, followed by public transport not available (8.6%, N=60), health centers are too far (8%, N=56), response of the doctor is rude (7.3%, N=51), No one accompanying me to hospital (7.1%, N=50), cannot communicate properly (7%, N=49) and response of the health worker is rude (5.7%, N=40) are the problems faced by the urban women in getting health facilities.

There are many problems that women encounter to obtain the health information. Prominent they are how and whom to approach, what services are offered, services too expensive, lack of time and distance of facilities.

5.7 CONCLUSION:

However community is suffering from lack of access to health care due to distance of health care facilities, and in getting an escort while going to hospital, access to women doctors, lack of knowledge about whom to approach for their problem and matching of their leisure time to go to hospital. Additional problems are lack of proper communication with doctor, waiting time at hospital, affordability of the cost and response of the health workers. In view of the social network, mass media are important sources of information for women. On explaining about the library, respondents expressed their need for a library. A large number of the respondents were interested in educative materials. They feel that awareness helps them to converse meaningfully with doctors while maintaining anonymity (especially in case of women) ensured.

To summarize, it is clear from the study that whatever may be the channel of communication, including doctor-patient interaction, it is felt that awareness/education can sensitize the community, through not one media cannot educate them completely. Further, it was established that need-based information service is very effective in creating a better understanding about health. Hence, libraries are most suitable in providing a wide arena for the choice of health education materials and thus helping them in acquiring more knowledge.

CHAPTER – 6

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION:

In this chapter an attempt has been made to give in summary form the important findings of the study health information support for urban women in Bijapur District (Now Vijayapura) covering 700 urban women of 35 wards of districts. For convenience, this chapter has been divided in to various sections, Summary of findings, recommendation, areas of further research and conclusion.

6.2 SUMMARY OF FINDINGS:

The summary of findings has been discussed in four sections as under:

6.2.1 General information and health information needs of urban women in Bijapur District: Summary of findings

1. Large number of women under study belong to the age group of 26 to 45 years (39%, N=273) followed by 46 years above (36.4%, N=255).
2. More than one third of women respondents have studied up to SSLC (39.9%, N=279), while a very small proportion of women under study are illiterates (6%, N=42).
3. The study population comprises of 45.6% of OBC (N=319), 34.1% of GM (N=239) and 20.3% of SC/ST (N=142) urban women.
4. More than 67% of urban women under study are married (N=472).
5. Kannada being the state language is known by the majority of the urban women (98.6%, N=690).
6. Urban women housewives/unemployed (45.1%, N=316) constitute a larger proportion of the study population.
7. Majority of the respondents under study have no income (63.7%, N=446).
8. Televisions are found in 98.4% of the houses (N=689). More than 91% of urban women have telephone/mobiles (N=642).

9. The ranking of health information need indicates that hospital and nursing home, food and diet regulation are the top three ranked health information needs of urban women. Prevention of diseases in general, obstetrics, surgery and therapeutics, etiology and pathology are the least ranked health information needs by the urban women.

6.2.2 Use of mass media in Bijapur District: Summary of findings

10. Majority of the urban women under study do not listen to radio programmes (68.4%, N=479).
11. Majority of women prefer morning (57.9%, N=128) hours as the best time to listen to radio.
12. More than half (54.3%) of women spend less than thirty minutes in listening to the radio (N=120).
13. 85.5% (N=189) of women listen to health related programmes on radio.
14. 61.4% (N=116) of urban women under study listen to 'Radio Doctor' programme on radio. This programme has been most informative health programme to the women.
15. Urban women under study listen to 'Special programmes on health care' ($\bar{x}$=2.18) on radio and it is ranked number one programme by the listeners. 'Talk shows' ($\bar{x}$= 1.71), 'Public service announcements' ($\bar{x}$=1.59) and 'Advertising' ($\bar{x}$=1.47) which are rated as third, fourth and fifth radio programme listen by the urban women.
16. 95.8% (N=181) of women assertively say that radio as an information agency.
17. 58.5% (N=106) of women feel that radio programmes are useful information agencies.
18. Larger proportion of urban women (91.3%, N=639) watch television.
19. Nearly one third of women spend 30 mints to 1 hour to watch television (32.7%, N=209).
20. Most of urban women watch TV during late evening (51.8%, N=331).
21. 67% (N=428) of the women do agree that they are aware of the women health programme telecasted by television.

22. Special programmes on health ($\bar{x}$=2.18, 1st rank) were the most preferred program on television for getting health information, followed by news stories ($\bar{x}$=2.02, 2nd rank), talk shows ($\bar{x}$=1.99, 3rd rank), public service announcements ($\bar{x}$=1.74, 4th rank), advertising ($\bar{x}$=1.70, 5th rank) programmes were watched by urban women.
23. 91.8% (N=393) of urban women under study accept television as an information supporting agency.
24. More than half (52.9%, N=208) of urban women rate television as a useful agency that supports their information requirements.
25. More than half percents of urban women i.e. 56.9% (N=398) read newspapers.
26. 58.3% (N=232) of the women spend less than 30 minutes to read newspapers.
27. Majority (53%, N=211) of them read newspapers during morning.
28. 'Vijaya Karnataka' is the most popular newspaper read by 52.3% (N=208) of urban women under the study.
29. 46.2% (N=184) of urban women read 'Vijaya Karnataka (LavalaVK)' newspapers supplements, 41.2% (N=164) of women prefer to read 'Vijayavani (Lalita)' supplement.
30. Article in newspapers ($\bar{x}$=2.34, 1st rank), health magazines ($\bar{x}$= 2.08, 2nd rank), publicity materials from health organizations ($\bar{x}$= 1.54, 3rd rank) were the top ranked sections read by the urban women.
31. 94.7% (N=377) of them feel that newspapers support their health information requirements.
32. 45.6% (N=172) of women feel that newspaper is a useful information supporting agency.
33. More than sixty percent of the women (60.1%, N=421) do not read women related magazines/periodicals.
34. 11.4% (N=32) of urban women read 'Taranga', 10% (N=28) of women read 'Grihshobha' and 'Femina', 'Tushar' is read by 6.8% (N=19) of women and 6.4% (N=18) of women read 'Sakhi' periodicals.
35. 'Women's Health' ($\bar{x}$=2.07, 1st rank), 'Health and Nutrition' ($\bar{x}$=1.73, 2nd rank), 'Fitness' ($\bar{x}$=1.62, 3rd rank), 'Sanjeevini' ($\bar{x}$=1.56, 4th rank), 'Arogyavani' ($\bar{x}$=1.50, 5th rank) are the top five magazines read by urban women.

36. 93.2% (N=260) of urban women feel that magazines/periodicals support their health information requirements.
37. 66.2% (N=172) rate the usefulness of magazines/periodicals as useful in supporting their information requirements.
38. 61.7% (N=432) of urban women do not read such books.
39. 95.9% (N=257) of urban women feel that health related books supports their information requirements.
40. Hardly 56.4% (N=145) of urban women rate health related books as useful for their usefulness.
41. Majority of women i.e. 55.9% (N=391), consult human resources to collect health information.
42. 77.2% (N=302) of women consult doctors while 64.7% (N=253) consult family members and 47.8% (N=187) consult friends/neighbours for supporting their health information requirements.
43. 88.2% (N=345) of urban women feel that human resources support their health information requirements.
44. 50.7% (N=175) of urban women rate human sources as useful in supporting their health information requirements.
45. More than forty percent of the urban women under study that is 41.3% (N=289) consult institutional sources to collect health information.
46. More than 75.4% (N=218) of urban women approach hospitals, 23.5% (N=68) consult Government organisation and 8.6% (N=25) of urban women consult libraries for their health information requirements. Urban health center (3.5%, N=10), community health centers (CHCs) (2.8%, N=8), mobile health clinic (2.1%, N=6), non government organization (1.7%, N=5), urban primary health centers and district AIDS prevention and control unit (1.4%, N=4) and district surveillance unit (0.7%, N=2) are the least consult institutional resources for supporting their health information requirement.
47. Majority of urban women (84.4%, N= 591) do not use library.
48. 61.5% (N=67) of urban women have become members of the library.

49. 32.1% (N=35) of the respondents preferred to visit college library. 27.5% (N=30) of the respondents preferred university library, 21.1% (N=23) of women preferred to visit school library and hardly 19.3% (N=21) of the urban women preferred public library for gathering information.
50. 62.4% (N=68) of urban women visit library rarely.
51. 52.3% (N=309) of the respondents quoted lack of time is the reasons for not visiting the library.
52. 37.6% (N=41) of women prefer to read information on education in libraries and 30.3% (N=33) of women preferred current affaire information in library.
53. 78.2% (N=226) of urban women feel that institutional resources support their information requirements.
54. Institutional resources are rated useful by 56.2% (N=127) of urban women.
55. 54.6% (N=382) of urban women do not consult internet and e-resources for their health information requirement.
56. 61% (N=194) of urban women collect health related information through internet and e-resources.
57. Very few women collect information through internet on general health issues (24.7%, N=48), diet/food (18%, N=35), women health issues (12.4%, N=24) and fitness (10.3%, N=20) this is mainly preferred to gather health information on internet and e-resources.
58. 94.8% of women (N=184) claim that Internet and E-resources support their health information requirements.
59. 51.2% (N=94) of women rate internet and e-resources as useful.
60. (1.8%, N=7) don't have smart phone do not get exact health information (1.6%, N=6), don't know how to get health information (1.3%, N=5) were quoted as the reasons given by the urban women for not using internet and e-resources.

6.2.3 Knowledge of understanding health problem: Summary of findings

61. Majority of the women do not have knowledge of understanding their health problems (85.1%, N=596).
62. Very less number of urban women understand general health issues like Headache (22.1%, N=23), Stress and tension (11.5%, N=12) and Cough, cold, fever (10.6%, N=11).
63. More than half of the women don't understanding of the treatment suggested by the doctor (56.6%, N=396).
64. 63% of the women respondents don't remembering the name of the medicine taking (N=446).
65. 49.3% women respondents reveal that, they interested to know their health problem (N=345).
66. Nearly 93% of the women respondents understanding their health problem from concern doctor (92.4%, N=319).

6.2.4 Awareness level of women as regards the Government programmes: Summary of findings.

67. 65.1% (N=456) of the women are aware of at least one programme of the Government.
68. 76.1% (N=347) of urban women are aware of 'Bhagyalakshmi', 69.3% (N=316) of women are aware of 'Arogya bhagya', 66.4%, (N=303) of women are aware of 'Thayi Bhagya', 64.9% (N=296) of women are aware of 'Mahila Bhagya', 59% (N=269) of women are aware of 'Arogya Kavacha' programmes, 50.4% (N=230) of women are aware of 'Yeshasvini Cooperative Farmers Health Care Scheme'.
69. 76.5% (N=349) of women claimed that they were able to know about Government programmes through television, 57.9% (N=264) of women aware of Government programmes through newspapers. 45.8% (N=209) of women also claimed that they were aware of Government programmes through their friends.
70. Nearly one third of urban women i.e. 49.1% (N=224) claim that available information on Government programmes is useful for them.

71. 6.3% (N=44) of the women are beneficiaries of health programmes of the Government.
72. Very less number of women are benefited health schemes i.e. 36.4% (N=16) of urban women are benefited through 'Yeshaswini' and 27.3% (N=12) are benefited under 'Arogyabhagya'.
73. 17.1% (N=120) of the women opine that they don't know what services offered, 16.1% (N=113) find that they don't know how and whom to approach for their health problem, 15.1% (N=106) of the respondents opinion that the services provided in the hospital is too expensive and there is no time to women to get health information are the problems faced by the urban women in getting health facilities.

6.3 RECOMMENDATIONS:

Mass media

1. Citizens need orientation and education in the use of television, radio and print materials, human and institutional sources including internet in using health information as "the wealth of a nation depends on the health of the people.
2. There is a need for creating awareness among general public regarding television programs on health.
3. Health information should be disseminated through public service and advertisements rather than through other programs.
4. Awareness about internet as an important source of health information should be created among general public.
5. The information service can be achieved through many channels of communication like mass media, grass root level health workers, doctor-patient interaction and libraries.
6. Public health campaigns on mass media should continue to be strengthened to impose positive influence on women.
7. Accurate health care information should be transmitted through electronic media, print media, traditional media, or camp, conference, seminar, symposium, publicity frequently as and when necessary.

8. Central and State Government should disseminate the information on health to the general public by television, radio, newspapers, magazines, and the internet including social media which can reach huge population.
9. Prevent the commercial advertisements which lead to dangerous and unhealthy lifestyle from telecasting on television. For example – Eating pizza and burger, unnecessary cosmetics which will have side effects on the general health of the people.
10. Plan and telecast television shows on health comparable to "Satymeva Jayate" by famous actor Amir Khan to alert the general public about health. Telecast specific programs on health problems on a regular basis which in turn will improve people perception, awareness, and knowledge of the health issues. Radio programs with specific health programs should be aired regularly and given wide publicity. Prime minister's address to the nation "Mann ki Baat" is frequently aired and it is monthly program. Similarly, programs on health should be launched through radio and given wide publicity.
11. National health portal of India (www.nhp.gov.in), Government of India website, has to act as the gateway to authentic health information to general public. Target information about diseases and preventive steps from vulnerable diseases. Host websites on health related topics at national, state, and district issues and health conditions.
12. Information on health may be converted into mind – boggling, eye-catching, attention grabbing or breath-taking forms and published on a daily basis in all newspapers as a mandatory for publishers of newspapers.

Library

1. Awareness among general public should be created about the different types of reading materials as sources of health information.
2. Librarians should take interest in providing health information to their users. Libraries should acquire health related materials to provide services to their clients.
3. Libraries should disseminate health care information such as health and nutrition, family welfare, public health, health schemes, health care facilities, communicable diseases, etc., effectively to the library users at the right time.

4. Some good local health journals/ newsletters in the local language should be subscribed by the library so that the library users may have access to make themselves conscious about health.
5. Health awareness programmes should be organized by the local clubs/ organisations from time to time in collaboration with concerned authorities. The recent trend in information flow is through wall writings, documentaries are also used to disseminate the information to the library users.
6. Awareness programmes on various diseases and health issues may be conducted at the premises of the library, with the involvement of the women.
7. Library may arrange outreach programs – exhibitions, displays, film shows, and lectures by experts, jointly with NGOs, extension workers, community clubs and other professional groups on health related issues. The focus should be on improving health information exchange through better information systems and services so as to provide right information to the right people in the right format and at the right time.
8. Libraries could also come together to form a consortium with allied partners in such areas like acquisition, resource sharing and networking so as to help in meeting the health information needs of users.
9. Libraries could plan and operate some community services in partnership with health related non-governmental organizations through sponsorships, trainings, and inter-library staff exchange programmes, resource loans and referral initiatives, just to provide services to users.
10. Educational programmes on health care topics like blood pressure screening, health insurance counseling and other health talks could be initiated to take place in the libraries with invitation of experts in these areas to speak to interested clients and the patron community members.
11. Support for publication of articles on local newspapers/bulletins written by University staff and library staff explaining which health care information should be encouraged and sustained by libraries.
12. University libraries should provide information about health and its values as a community asset; health awareness aims at acquainting the students and teachers with the rules of health and hygiene, etc.
13. Library may organize some seminars, informal talks, lectures, workshops, etc., on the various major issues.

14. Institutional sources such as the public library should be strengthened to provide health information to the users. All types of libraries should build the unique collection on general health.
15. Educational programmes on health care topics like blood pressure screening, health insurance counseling and other health talks could be initiated to take place in the libraries with invitation of experts in these areas to speak to interested clients and the patron community members.
16. The effective information services can be achieved with the support of well-equipped library and information system integrated to health care delivery system.
17. Research in health information communication science promote with the aim of bridging the gap in communication created by inadequate health literacy.
18. As Dr. S R Ranganathan has rightly said, "Right information to the right user at the right time" it is the responsibility of the library professionals to provide information relating to the health to the clienteles in anticipation or on demand.

ICT

1. The technology trends will lead to many new developments throughout the health information value chain. Health awareness development i.e. development in the fields of nutrition, sanitation, community health, prevention of water, food, air pollution are needed.
2. The internet access for health information is low. Compounding the situation is the poor delivery of health information services. Existing constraints to the internet access might encourage quick check of health information without giving adequate attention to cross-checking or verifying the authenticity of the information from other sources.
3. There is a need for practitioners in the Vijayapura city health sector to take an active position in providing timely and context-relevant information to the growing need for online health information.
4. There are currently several medical information websites that directly target the general population with the aim of providing information about health problems, self-care and prevention. However, this new technology also hides several shortcomings, such as: (i) uneven quality of medical information

available on the Internet; (ii) difficulties in finding, understanding and using this information; (iii) lack of access for the unconnected population; and (iv) the potential for harm and risks of overconsumption. To be able to overcome these dangers, it is important that public health practitioners and health professionals be involved in the design, dissemination and evaluation of web-based health and medical information.

5. Health websites or social media sites should support users to find people similar to themselves or with similar interests, and be able to accommodate users' personal health interests. For generic social networking sites, like Facebook, it should allow friends with similar health interests to form groups and communicate privately so as to create a safe and comfortable environment for health information exchange

Government

1. The government and nongovernmental organizations, agencies at the state and central level have to create public health awareness among citizens to keep good health.
2. Public health awareness should be conducted to create awareness and educate the citizens in the use of information sources for making best use of health information.
3. Health departments should employ more number of people for providing health education.
4. Awareness about the Government organizations as sources of health information should be created among general public.
5. Active involvement of elected representatives and people should be promoted.
6. Health awareness development i.e. development in the fields of nutrition, sanitation, community health, prevention of water, food, air pollution are needed.
7. Today health information is everywhere. To overcome the health information issues health information literacy regional model and forum is required.
8. Health budget is required to meet the National health policy goal "Health for All" it is quite long way to go achieve.

9. Similar to International YOGA day, launched by Prime minister of India, on significant health issues national level events needs to be regularly organized to create awareness about health among the general public.
10. The government of India has started "School Health Programme" with the aim of inculcating health seeking behavior of children. Some such programs need to be planned and extended to colleges, university students and women.
11. The Government of India has launched numerous health programs at the national level like - Preventive and promotive healthcare – Mission Indradhanush, Programmes for communicable diseases, Programmes for non-communicable diseases, National nutritional programmes, Programmes related to system strengthening, welfare, and many other programs. These programs need further strengthening. Some unique programs comparable to "Swach Bharat Abhiyan" should be launched with the participation of citizens to create health awareness of individuals and their lifestyle.
12. Similar to "Right to education", "Right to information", Government of India should enact a law through legislation viz., "Right to health information" as the fundamental right of every citizen of the country.

6.4 AREAS OF FURTHER RESEARCH:

Based on the review of existing literature and also on the findings of the study, following areas of research are suggested for further research.

1. Health information dissemination and Government
2. Health information support for rural women
3. Evaluation of mass media as health information supporting agencies for women
4. ICT and Women health information support
5. Health information need for women.

6.5 CONCLUSION:

The health information support for urban women in Bijapur district (Now Vijayapura) has been studied. The selection of sample respondents has been made from Vijayapura district. From Vijayapura district, 35 wards have been selected for this study. From each ward 20 respondents have been selected. Thus Total 35 wards and 700 respondents have been selected for this study. For every ward twenty women have been identified by using stratified sampling. The results of the study are summarized in the form of findings and recommendations have been made based on the results of the study.

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HEALTH INFORMATION SUPPORT FOR URBAN WOMEN IN BIJAPUR DISTRICT

Questionnaire

PART-I GENERAL INFORMATION

1. Name of the Respondent : _____
2. District/Village/Taluk : _____
3. Age : _____
4. Education : _____
5. Social Class : GM [ ] OBC [ ] SC/ST [ ]
6. Marital status : Unmarried [ ] Married [ ] Divorced/Widow [ ]
7. No of Children : _____
8. Languages Known : Kannada [ ] Hindi [ ] English [ ] Others _____
9. Occupation : _____
10. Income[monthly] : _____
11. Media facility available at home
Radio [ ] Television [ ]
Telephone/Mobile [ ] Newspaper/Magazine [ ] Others_____

PART-II HEALTH INFORMATION NEEDS

12. Indicate your needs with various types of health information by using the following scale.

Health Information	Highly Important	Important	Moderately Important	Moderately Unimportant	Un important	Highly Unimportant
Hospital & Nursing home						
Nursing						
Pharmaceutical						
Obstetrics						
Birth control						
Diseases						
Prevention of diseases in general						
Surgery & Therapeutics						
Public hygiene						
Personal hygiene						
Food						
Diet regulation						
Physical fitness						
Etiology						
Pathology						

PART-III USE OF MASS MEDIA

13. Are you listening to the programmes being broadcasted in Radio?

Yes [ ] No [ ]

14. If 'yes', Do you listen to Radio (All India Radio, Vijayapur) more frequently during

Morning	[ ]	Afternoon	[ ]
Early evening	[ ]	Late evening	[ ]

15. How much time do you spend in listening to radio programmes each day?

Less than 30 mints	[ ]	30 mints to 1 hour	[ ]
1 hour to 2 hour	[ ]	More than 2 hour	[ ]

16. Are you listening to the programmes related to women's health?

Yes [ ] No [ ]

17. If 'yes', which of the following programmes do you prefer to listen?

Radio Doctor	[ ]	Sakhi Saheli	[ ]
Arogyada Angala	[ ]	Others _____	

18. How do you rate the following radio programmes in getting health information?

1- None, 2- Little, 3- Some, 4-Greater extent, 5- Do not apply

News stories	[ ]	Public service announcements	[ ]
Talk shows	[ ]	Advertising	[ ]
Special programmes on health care	[ ]	Others _____	

19. Do you feel that radio is supporting your health information needs?

Yes [ ] No [ ]

20. If 'yes', to what extent its programmes are useful?

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

21. Do you watch Television?

Yes [ ] No [ ]

22. If 'yes', how much time do you spend in watching to television each day?

Less than 30 mints	[ ]	30 mints to 1 hour	[ ]
1 hour to 2 hour	[ ]	More than 2 hour	[ ]

23. Do you watch television more frequently during

Morning	[ ]	Afternoon	[ ]
Early evening	[ ]	Late evening	[ ]

24. Are you aware that there are women health related programmes in TV?

Yes [ ] No [ ]

25. If 'yes', which of the following programmes would you like to watch?

DD Chandana	Health	[ ]
	Hello Sakhi (live)	[ ]
	Arogya Bharatha	[ ]
	TV Doctor	[ ]
	Spon- RPT Health Programme	[ ]
	Beauty Tips	[ ]
	Yoga/Aerobics	[ ]
	Women's Programme	[ ]
	Chaluvina Chittara	[ ]
TV9 Kannada	Yoga Yoga	[ ]
	Ladies Club	[ ]
Kalki Kannada	Surabhi	[ ]
	Namaste Karunaadu (Mudra Yoga)	[ ]
	Namaste Karunaadu (Angaili Owshadhi)	[ ]
Udaya TV	Siri	[ ]
	Nati Vaidya	[ ]
Udaya News	Doctors	[ ]
Public TV	Nithya Sanjeevini	[ ]
	Yoga Phala	[ ]
Kasthuri TV	Lifeline Live	[ ]
Kasthuri Newz 24	Doctor's Diary	[ ]
Janasri News	Health center	[ ]
	Doctors Nature Clinic	[ ]
	Homeo Clinic	[ ]
	Clinic	[ ]
	Sanjeevini Clinic	[ ]
Samaya 24 x 7	Ladies Voice	[ ]
	Stri Samrajya	[ ]
Suvarna News 24x7	Dear Doctor	[ ]
News BTV	B Healthy	[ ]
	Workout/ Aerobics/Yogasutra	[ ]
	Naari Gallery	[ ]
ETV News Kannada	Hello Doctor	[ ]
Raj News 24 x 7	Herbal Medicine	[ ]
	Naturopathy Medicine	[ ]

Sarala Jeevana	Hello Doctor	[ ]
	Mane Maddu	[ ]
Praja TV	Sakhi Sukhi	[ ]
Zee TV	Yoga for you	[ ]
	Yogic Healing by Swami Ramdev	[ ]
Aastha	Yog Shivir	[ ]
	Ayurved Evam Jivan Darshan	[ ]
	Dhyan Yog	[ ]
	Khel Khel Me Yog	[ ]
	Seva Ganga	[ ]
	Sujok Therapy	[ ]

Hindi Channel _____ Health Programme _____

English Channel _____ Health Programme _____

Other Health Programme _____

26. How do you rate the following television programmes in getting health information?

1-None, 2- Little, 3- Some, 4-Greater extent, 5- Do not apply

News stories	[ ]	Public service announcements	[ ]
Talk shows	[ ]	Advertising	[ ]
Special programmes on health	[ ]	Others _____	

27. Do you feel TV Programmes are fulfilling your health information needs?

Yes [ ] No [ ]

28. If 'yes', to what extent these programmes are useful?

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

29. Do you read newspapers?

Yes [ ] No [ ]

30. If yes, where do you read newspapers?

Library	[ ]	House	[ ]	University	[ ]
School/ College	[ ]	Others _____			

31. How much time do you spend in reading each day?

Less than 30 mints	[ ]	30 mints to 1 hour	[ ]
1 hour to 2 hour	[ ]	More than 2 hour	[ ]

32. Do you prefer to read printed materials more frequently during

Morning	[ ]	Afternoon	[ ]
Early evening	[ ]	Late evening	[ ]

33. Which of the following newspapers do you read?

Kannada Prabha	[ ]	Deccan Herald	[ ]	Prajavani	[ ]
The Hindu	[ ]	Samyuktha Karnataka	[ ]	Times of India	[ ]
Vijaya Karnataka	[ ]	Indian Express	[ ]	Udayavani	[ ]
Vijaya Vani	[ ]	Local Newspapers	[ ]	Others _____	

34. Which of the following newspapers women/health supplement you read?

Vijaya Vani (Lalita)	[ ]	Vijaya Karnataka (LavalaVK)	[ ]
Samyuktha Karnataka (SKcity)	[ ]	Udayavani (Avalu) (Saptahika sampada)	[ ]
Express Sunday (Magazine (Well ness))	[ ]	Sunday Times (Life (Health))	[ ]
Prajavani (Bhoomica)	[ ]	Others _____	

35. How do you rate the following types of printed materials in getting health information?

1-None, 2- Little, 3- Some, 4-Greater extent, 5- Do not apply

Health magazines	[ ]
Articles in newspapers	[ ]
Medical books	[ ]
Publicity materials from Health Organizations	[ ]
Advertisements : Posters/Pamphlets	[ ]
Any Others_____	

36. Do you feel that newspapers will be helpful (Support) your health information needs

Yes [ ] No [ ]

37. If 'yes', indicate to what extent newspapers are useful to you?

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

38. Do you read magazines?

Yes [ ] No [ ]

39. If 'yes', which of the following journals, magazines do you prefer to read?

Sudha	[ ]	Taranga	[ ]	Priyanka	[ ]
Kasturi	[ ]	Grihshobha	[ ]	Mayura	[ ]
Tushar	[ ]	Grihlakshmi	[ ]	Karmaveera	[ ]
Cosmopolitan	[ ]	Debonair	[ ]	Society	[ ]
Women's Era	[ ]	Femina	[ ]	Frontline	[ ]
India Today	[ ]	Priyanka	[ ]	The Week	[ ]
Roopatara	[ ]	New woman	[ ]	Vogue	[ ]
Sakhi	[ ]	Nisarga	[ ]	Butti	[ ]
Reader's Digest	[ ]	Manasa	[ ]	Drishti	[ ]
Wisdom	[ ]	Chutuka	[ ]		
NavaragaSangama	[ ]	Others_____			

40. How do you rate the following health magazines in getting information?

1.None 2. Little 3. Some 4. Greater extent

Health and Nutrition	[ ]	Women's Health	[ ]	Arogyavani	[ ]
Health	[ ]	Prevention	[ ]	Fitness	[ ]
Yoga	[ ]	Swasthya Aur Jeevan	[ ]	Health Plus	[ ]
Chandrodaya	[ ]	HEAL	[ ]	Yog Sandesh	[ ]
Vydyaloka	[ ]	Health Cafe	[ ]	Arogya Sandesh	[ ]
Health Vision	[ ]	Sanjeevini	[ ]		

Any other (Please specify) _____

41. Do you feel that journals and magazines are useful in fulfilling your health information needs?

Yes [ ] No [ ]

42. If 'yes', indicate to what extent these are useful.

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

43. Do you read books related to women health?

Yes [ ] No [ ]

44. Do you feel that books are supporting your health information requirements?

Yes [ ] No [ ]

45. If 'yes', indicate to what extent these are useful to you?

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

46. Do you consult human sources to collect health information?

Yes [ ] No [ ]

47. If 'yes', which are the following human resources would you prefer to collect health information.

Concerned Professionals	[ ]	Social Workers	[ ]
Nurses	[ ]	Friends/Neighbours	[ ]
Family Members	[ ]	Librarian	[ ]
Doctors	[ ]	Health workers	[ ]
Traditional Healer	[ ]	Primary Healthcare Workers	[ ]
Govt. Information Officers	[ ]	District Health Officer	[ ]
Taluk Health Officer			[ ]
Medical Officers of the Primary Health Centers			[ ]

Others _____

48. Do you feel human resources support your health information needs?

Yes [ ] No [ ]

49. If 'yes', indicate to what extent these are useful to you?

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

50. Do you contact institutional resources to collect health information?

Yes [ ] No [ ]

51. If 'yes', which of the following institutional resources do you prefer to collect health information.

Government Organization	[ ]	Non Government Organization	[ ]
Hospitals	[ ]	Libraries	[ ]
Nature care centers	[ ]	Mobile Health Clinic	[ ]
Women organization	[ ]	Urban Primary Health Centers	[ ]
Urban Health Center	[ ]	District Surveillance Unit	[ ]
Community Health Centers (CHCs)			[ ]
District AIDS Prevention & Control Unit			[ ]

Others_____

52. Have you used library?

Yes [ ] No [ ]

53. If 'Yes', are you a member of the library?

Yes [ ] No [ ]

54. Which of the following libraries do you prefer to visit?

Public Library	[ ]	School Library	[ ]
College Library	[ ]	University Library	[ ]
Special Library	[ ]	Please mention if any other_____	

55. When do you visit the library?

Daily	[ ]	Once a week	[ ]	Monthly	[ ]
Yearly	[ ]	Rarely	[ ]	Never	[ ]

56. If not visiting, specify reasons for not visiting the library

No library available	[ ]	Not interested	[ ]
Do not know reading and writing	[ ]	Lack of time	[ ]
Information available on fingertips	[ ]	Other _____	

57. What type of information do you get from the library?

Education	[ ]	Law	[ ]	Health	[ ]
Social Welfare	[ ]	Employment News	[ ]	Sports	[ ]
Agriculture	[ ]	Economic/Finance	[ ]	Current Affaires	[ ]
National	[ ]	International	[ ]	Local News	[ ]
Science	[ ]	Cinema	[ ]	Entertainment	[ ]
Art & Trends	[ ]	Advertisement	[ ]	Government Programs	[ ]

Others _____

58. Do you feel that institutional resources will provide you necessary health information?

Yes [ ] No [ ]

59. If 'yes', how much you are benefited from institutional information resources.

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

60. Do you use Internet and E- resources?

Yes [ ] No [ ]

61. Do you collect women health related information through Internet and E-resources?

Yes [ ] No [ ]

62. If 'yes', which of the health information you prefer to collect through Internet and E-resources.

_____

63. Do you feel that Internet and E-resources will provide you necessary health information?

Yes [ ] No [ ]

64. Indicate to what extent these are useful

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

65. If you say 'No', Please give reason?

_____

PART-IV KNOWLEDGE OF UNDERSTANDING HEALTH PROBLEM

66. Could you understand your health problem?
If yes, please name it -

_____

67. Could you understand the treatment suggested by the Doctor?
Yes [ ] No [ ]

68. Do you remember the name of the medicine?
Yes [ ] No [ ]

69. Do you like to know, what is your health problem
Yes [ ] No [ ]

70. If yes, how do you want to know it from?

Doctor	[ ]	Reading	[ ]	Seeing	[ ]
Neighbors	[ ]	Family members	[ ]		
Oral explanation by similar patient			[ ]		

Please specify any other _____

PART-V AWARENESS OF GOVERNMENT PROGRAMMES

71. Are you aware of Government Schemes/ programmes?
Yes [ ] No [ ]

72. If 'yes', show your awareness with the following Government Schemes/ programmes related to women health?

Arogya Bhagya	[ ]
Mahila Bhagya	[ ]
Arogya Kavacha	[ ]
Bhagyalakshmi	[ ]
Thayi Bhagya	[ ]
Janani Suraksha Yojana	[ ]
Balika Samriddhi Yojana (BSY)	[ ]
Kishori Shakti Yojana (KSY)	[ ]
Prasooti Araike	[ ]
Madilu	[ ]
Urban Streeshakti Scheme	[ ]
Swadhar	[ ]
Yeshasvini Cooperative Farmers Health Care Scheme	[ ]
Swawlamban	[ ]
National Maternity Benefits Scheme	[ ]
Rural Health component of the Minimum Needs Programme	[ ]
Medical Development programme and Hospital Pharmacy Programme	[ ]
National 'AIDS' Control Programme	[ ]
Reproductive Child Health	[ ]
National Tuberculosis Control Programme	[ ]
National Vector Borne Disease Control Programme	[ ]
Health Education and Training Programme	[ ]

Nutrition Programme [ ]
Amruta Yojane [ ]
Swarna Jayanti Shahari Rozgar Yojana (SJSRY) [ ]
Santhwana [ ]
Others _____

73. Indicate through which of the following, you will come to know about Government Programmes on health.

Radio	[ ]	Television	[ ]	Newspapers	[ ]
Friends	[ ]	Government office	[ ]	Libraries	[ ]
Neighbours	[ ]	Family Members	[ ]	Associations/Institutions	[ ]
Concerned Staff	[ ]	Social workers	[ ]	Teachers	[ ]

Others _____

74. How far the health development programmes of the Government are useful to you?

Highly useful	[ ]	Useful	[ ]	Moderately useful	[ ]
Moderately Unuseful	[ ]	Unuseful	[ ]	Highly Unuseful	[ ]

75. Are you benefited from the health development programmes of the Government?

Yes [ ] No [ ]

76. If 'yes', mention name of the programme.

_____
_____

77. Mention the problems faced by you in accessing health care facilities?

We don't know how/whom to approach	[ ]	Public transport not available	[ ]
Distance of facilities	[ ]	Health centers are too far	[ ]
No one accompanying me to hospital	[ ]	Timing does not match	[ ]
There is no time	[ ]	Poor service offered	[ ]
Cannot communicate properly	[ ]	Response of the doctor is rude	[ ]
Don't know what services offered	[ ]	I don't have the need yet	[ ]
Services too expensive/ Too costly	[ ]		

No female health worker/No lady doctors [ ]
Don't know Governmental Schemes/Programmes [ ]
Any other (Please specify) _____

78. Give your suggestions to improve access to health information

_____
_____

Signature

ABBREVIATIONS

AIR	All India Radio
ANM	Auxiliary Nursing Midwives
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
BPL	Below Poverty line
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CHI	Consumer Health Information
CHW	Community Health Workers
CME	Continued Medical Education
CWHN	Canadian women's health network
DHF	Dengue Haemorrhagic Fever
DiTV	Digital Interactive Television
DTC	District Tuberculosis Centre
DTP	District Tuberculosis Programme
DWCD	Department of Women and Child Development
EMT	Emergency Medical Technician
ENT	Ear, Nose and Throat
ERIC	Education Resources Information Center
ESD	External Services Division
ESI	Employees' State Insurance
FCTC	Framework Convention on Tobacco Control
FRU	First Referral Units
GIS	Geographic Information Systems
HBNC	Home Based Newborn Care
HIB	Human Information Behaviour
HIL	Health Information Literacy
HINTS	Health Information National Trends Survey
HIS	Health Information Seeking
HISTS	Health Information Support Telephone Service
HIT	Health Information Technology

HIV/AIDS	Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome
HIWQ	Health Information Wants Questionnaire
ICDS	Integrated Child Development Service
ICT	Information Communication Technologies
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Programme
IGMSY	Indira Gandhi Matritva Sahyog Yojana
ILSA	International Law School Association
IMNCI	Integrated Management of Neonatal & Childhood Illnesses
IMR	Infant Mortality Rate
IT	Internet Technology
IUD	Intrauterine Device
JSSK	Janani Shishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana
KSAPS	Karnataka State AIDS Prevention Society
LISA	Library and Information Science Abstracts
LISTA	Library, Information Science and Technology Abstracts
LPS	Low Performing States
MDM	Mid-Day Meal
MMR	Maternal Mortality Rate
MoHFW	Ministry of health and Family Welfare
MoU	Memorandum of Understanding
MoWCD	Ministry of Women and Child Development
MS	Multiple Sclerosis
NACP	National AIDS Control Programme
NAMP	National Air Quality Monitoring Programme
NBCC	New Born Care Corner
NBSU	New Born Stabilization Units
NCD	Non-Communicable Diseases
NGCP	National Goiter Control Programme
NGO	Non Government Organization
NHIS	National Health Interview Survey

NHM	National Health Mission
NHP	National Health Policy
NICU	Neonatal Intensive Care Unit
NID	National Immunization Day
NIDDCP	National Iodine Deficiency Disorder Control Programme
NLEP	National Leprosy Eradication Programme
NMBS	National Maternity Benefit Scheme
NMHP	National Mental Health Programme
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke
NPHCE	National Program of Health Care for the Elderly
NPPCD	National Programme for Prevention and Control of Deafness
NRC	National Register of Citizens
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Karyakram
NTCP	National Tobacco Control Programme
NUHM	National Urban Health Mission
PCOS	Polycystic Ovary Syndrome
PHC	Primary Health Care
PHU	Primary Health Unit
PICU	Pediatric Intensive Care Unit
PMSSY	Pradhan Mantri Swasthya Suraksha Yojana
PPP	Purchasing Power Parity
RCH	Reproductive and Child Health
RFS	Radio Frequency Systems
RHI	Reproductive Health Information
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infections
SNCU	Special Newborn Care Unit
STI	Sexually Transmitted Infections

TB	Tuberculosis
TBA	Traditional Birth Attendants
TINQ	Toronto Information Needs Questionnaire
TV	Television
U-CHC	Urban Community Health Centre
UFE	Uterine Fibroid Embolization
UNICEF	United Nations International Children's Emergency Fund
UPHC	Urban primary health centre
U-PHC	Urban Primary Health Centre
USA	United States of America
UT	Union Territories
VCU	Virginia Commonwealth University
WHN	Women’s Health Network
WHO	World Health Organization

AVAILABILITY OF HEALTH CARE SERVICE INFORMATION ON INTERNET: A STUDY OF VIJAYAPURA CITY

Shobha Patil

P.G. Tadasad

An attempt is made in this paper to provide an overview of the availability of health care service information on the Internet based on a study of websites of health service providers. Health information is one of the most frequently sought on the Internet. Internet Information technologies herald a major change in the dissemination of health and medical information, with the promise of transferring knowledge from health professionals to the general public. Accessibility to online clinical and health information is essential for better health outcomes. There are currently several websites and search engines that provide health care service information. But qualitatively the information provided by them is not satisfactory. On the other hand its usage is also in question due to various factors. Furthermore, there is a need for practitioners in the Vijayapura city health sector to take an active position in providing timely and context-relevant information to the growing need for online health information. The study concludes that it is an opportunity for information professionals to take a lead position in regulating and ensuring the availability of health-related information, especially that related to local health services. Such efforts will also complement existing initiatives aimed at improving active participation of the Vijayapura city people in promoting and sustaining healthy practices.

Keywords: Health Care; Health Information; Internet; Vijayapura.

INTRODUCTION

The Internet provides rich and versatile platforms for diverse interactions and sharing of information [1]. Health information is one of the most frequently sought topics on the Internet. Millions of people are using the Internet to get health information. Thousands of Websites are offering health care service information. Some of these sites are reliable and up-to-date; many are not. An attempt is made in this paper to provide an overview of health care service information on Internet.

Shobha Patil
Department of Library & Information Science,
Karnataka State Women's University,
Vijayapura, Karnataka, India
shobhapatils@gmail.com

P.G. Tadasad
Department of Library & Information Science,
Karnataka State Women's University,
Vijayapura, Karnataka, India
pgtadasad@gmail.com

HEALTH INFORMATION AND INTERNET

Interest in the Internet as a communication tool for health-related information is growing rapidly [2]. The profile of online health consumers can be broadly defined as patients, patients' friends/relatives, and citizens in general [3]. Internet-based health information is accessed from a variety of sources, including websites run by organizations, homepages run by individuals, and online support groups where people actively exchange health information and blogs. Since more people using the Internet as a source of health information the issue of credibility and trust on websites becomes important [4]. Online health information can increase patients' knowledge, competence, and engagement related to health decision-making strategies.

In the late 1990s researchers began to note that many people were using the Internet to seek health information, despite various problems with the quality of information. There is a premise that patients with access to their personal health information presented in a form they can understand will be able to interpret and learn from this information in a way that benefits them. Various social forums exist in which anyone can share conversations about health with their peers. Such forums are especially popular among patients who seek to have conversations with other patients with a similar medical concern. Those who participate in online communities which discuss health issues report getting relief about their health worries, perceiving more control over their health and medical condition, having more medical knowledge, and having more personal agency overall [5].

Health information can empower people to make health decisions and to talk to their physician, resulting in a more patient-centred interaction between patient and health professionals. Among currently available technologies only the Internet has the potential to deliver universal access to up-to-date health care information [6]. Accurate and up-to-date information is vital to maintain quality of health care. During the past decade, many health information resources have been developed and available online for use by health care professionals [7].

The Internet has been used by healthcare professionals to obtain and share large amounts of medical information and to monitor diseases. The knowledge of the Internet as an important health information resource for physicians have greatly improved during the past decade as a result of patterns of use and medical impact measures [8]. The Internet has brought about flexible communication between patients and doctors by empowering patients with information. It has also revolutionized the compilation, assessment and distribution of information relating to healthcare [9].

ONLINE SOURCES OF INFORMATION

Internet-based health information is accessed from a variety of sources, including:

- Websites run by organisations
- Homepages owned by individual doctors.
- Online support groups where people actively exchange health information; and
- Blogs authored by health advocates, caregivers or those pursuing self-help [10].

Health Profile of Vijayapura District

Vijayapura city, formerly known as Bijapur, is the district headquarters of Vijayapura District of Karnataka state. The city has a population of 326,360 as per 2011 census. Total literacy rate of the city is 73.42 (239631) which is less than the state literacy rate (75.36) and the literacy rate among men is 77.89 (128615) and among women it is 68.85 (111016) which is slightly higher than the state literacy rate (68.1) among women.

The city of Vijayapura is the major city in the vicinity of 100 km radius having advanced medical facilities. It has long history of providing medical facilities dating back to medieval period by 'Ayurvedic Vaid' and later during Adilshah's period by 'Unani Hakims'. The first allopathic dispensary was started in the year 1871. Over a period of 135 years the number of hospitals and the quantity of health services provided to the people in the city has a seen a remarkable growth. After independence the Government of Karnataka opened many hospitals. Similarly private hospitals, clinics, and multi-speciality hospitals have been established.

In Vijayapura district health care facilities and services are made available and accessible through CHCs, PHCs and taluk hospitals in rural and urban areas. The PPP mode has improved overall healthcare facilities and services in Vijayapura district [11].

Presently, the city has many prominent hospitals providing advanced health services. Besides this the city has many blood banks, ambulance services, pathological and diagnostic laboratories, health clubs, nursing homes, maternity homes, pharmaceutical vendors, health care instrument vendors and hundreds of medical shops. Every agency is committed to provide mandatory information to the community. Taluk-wise details of health centres are given in table 1.

Table 1: Taluk Wise details of Health Centers 2011-12

Taluks	Allopathic Hospitals	Indian System of Medicine Hospitals	Private Hospitals	Primary Health Centers	Community Health Centers
BasavanaBagewadi	2	-	1	14	1
Indi	4	-	5	14	2
Muddebhihal	3	-	2	9	3
Sindagi	2	-	5	9	3
Vijayapura	63	1	63	14	-
Total	**74**	**1**	**76**	**60**	**9**

AVAILABILITY OF HEALTH INFORMATION ON INTERNET

A great variety of information sources are now available and accessible online. These include search engines like Google, Yahoo, Alta Vista, Lycos, Mama, etc.; databases like MEDLINE/PubMed, Scopus, Web of Knowledge, EMBASE, African Index Medicus; portals, gateways, digital archives, libraries and institutional repositories. Recent, reliable, quality and up-to-date healthcare information are also available on websites of academic and health institutions, professional associations, government and non-government organizations. In addition, some government and not-for-profit organizations such as the National Institutes of Health (NIH) and Bioline International have digital archives, which provide free full-text articles. Medical dictionaries, encyclopedias, abstracts and indexes, bibliographies, atlases, videos and drug information sources are also available online [12].

An advanced Google search was made to know the availability of health care services information on the Internet. It is noticed that quantitatively the amount of information available on the Internet is more but qualitatively it is not satisfactory.

The city has three major hospitals Shri B M Patil Medical College Hospital & Research Centre; Al-Ameen Medical College and Government District Hospital. The Government hospital does not have its own hospital website and the remaining two have their websites as a part of their colleges. Shri B M Patil Medical College Hospital & Research Centre website provides information on health services, facilities, additional services and contact information. Al-Ameen Medical College Hospital's website provides information on their services, facilities and contact numbers. The information is available only in English language. Among the private hospitals only four hospitals - Sasnur Hospital (http://sasnurhospitals.com/), Dr. Bidari's Ashwini Hospital(http://www.ashwinihospital.org/), Kidney Foundation (http://drsbpatil.com/) and Ayush Hospital (http://glayushhospital.com/) have their own websites. Sasnur Hospital's website provides information on full spectrum of women's health care services, facilities, appointment, events, hospital timings, contact details. Dr. Bidari's Ashwini Hospital's website provides information on facilities, special services, corporate service-research and development, 24 x 7 enquiry, make an appointment, preventive health check, pharmacy open 24 x 7, ambulance facilities and contact details. Kidney Foundation's website includes information on specialisation and appointment information, etc. Ayush Hospital's website provides information on facilities, services, specialities, doctors' information and contact information.

Other prominent hospital information are available on Internet through local search engines like-
www.hospitalkhoj.com, http://www.justdial.com/, http://www.listbesthospitals.com/, http://www.vijapuraonline.in/, www.hospital.cybo.com, http://www.rainrays.com/, http://www.bijapur.nic.in/tele_index.html, http://maps.mapmyindia.com/, https://www.asklaila.com. Only bare minimum information like contact details, phone numbers of hospitals and location information, maps, views, votes, reviews and ratings are available. Very few hospitals have provision for appointment through Internet.

Only minimum information about individual doctors and consultants like dentists, gynaecologists, dermatologists, paediatricians, psychiatrist, and general physicians was available on Internet through the local search engines.

The other health care services include pathological and diagnostic laboratories, medical shops, medical instruments vendors, blood banks, fitness and health clubs, etc.

Some of the important ayurvedic hospitals in the city of Vijayapura offering traditional ayurvedic treatment methods are Nagur Hospital and Ayurvedic College, Government Ayurvedic Hospital, Agnivesh Ayurved Chikitsalaya, Ayurvedic Vidyalaya Hospital, etc. http://www.justdial.com/ a local search engine provides contact information. Another local search engine https://www.sehat.com provides a list of Ayurvedic hospitals with its profile, list of doctors and their phone numbers for appointments, but the links when accessed do not provide further results. It provides reviews, maps; https://www.chikitsa.com provides ask a doctor online facility. http://www.vijapuraonline.in/ and www.asklaila.com provides only contact information of Ayurvedic hospitals.

There are many hospitals in the heritage city of Vijayapura, specialized in advanced treatment of eye. These hospitals offer service of specialists in the field of care and treatment of eye problems. Some of the famous eye hospitals in the Vijayapura district are Kembavi Eye Hospital, Biradar Eyes Hospital, Anugraha Eye Hospital, etc. http://www.justdial.com/ include contact information, votes, maps and reviews.

Health clubs are active in the city of Vijayapura to provide proper training and guidance in health care and body fitness. Modern-day health clubs are playing a vital role in giving a boost to the weakening physical stamina. Most of the Fitness clubs offer a wide range of exercise equipments that takes care of both mental stress and health stability. There are many famous gymnasiums, fitness centers and weight loss centers in Vijayapura. Few of the popular fitness centers in Vijayapura are Diamond Gym, Dr Arun's fitness center, Healthline Enterprises, Health Line Fitness Club. Gymnasiums and fitness centers have become a part of life style. http://www.justdial.com/, http://www.vijapuraonline.in/ includes contact information, maps and reviews. http://maps.mapmyindia.com/ provides map of the health clubs.

Yoga is a better way of living for those who aim to get a healthy mind in a healthy body, thus the ultimate aim of yoga is to help the individual to transcend the self and attain enlightenment. There are many Yoga Centers in Vijayapura which offer a wide variety of special courses on yoga and related topics. The details of yoga and meditation centers in Vijayapura i.e. Prajapita, Brahma Kumaris, Ishwariya Vishwa Vidyalay. http://www.vijapuraonline.in, http://www.justdial.com/ provides a list of yoga centers with contact information.

We all know the importance of blood banks. Today most of the hospitals have blood banks attached to them to obtain blood quickly. Vijayapura district also has many blood banks associated with many hospitals and there is a branch of Indian Red Cross Society also providing their services in Vijayapura. The information of blood banks in Vijayapura are District Government Hospital, Dr. BNM Rural Ayurvedic Medical College, Lions blood bank, Dr. Karigoudars' blood bank, B. M. Patil Medical College, Hospital and Research Centre, Al Ameen Medical College Hospital. The blood banks in Vijayapura open for service 24 hours a day and 365 days a year. Official website of Vijayapura (http://www.bijapur.nic.in/) provides telephonic index on blood banks and www.justdail.com provides contact information of the blood banks.

Majority of the hospital information available through local search engines provide only contact information of the hospital. They don't have their own websites and those that have their own websites don't have Frequently Asked Questions (FAQs).The health information is available only in English language which decreases its usability. Even with the high literacy rate in Vijayapura district it is found that the usability of available online information regarding hospitals and health care is not optimum. The public use different means to collect information but accessing the online information is their last option. The reason can be said to be lack of awareness and knowledge about these websites. There is a need to overcome this

drawback by creating awareness among public regarding online health care service information.

HEALTH CARE SERVICE INFORMATION

Health care is the maintenance or improvement of health via the diagnosis, treatment, and prevention of disease, illness, injury and other physical and mental impairments in human beings. Health care is delivered by health professionals (providers or practitioners) in allied health professions, chiropractic, physician, associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology, and other health professions. It covers the work done in providing primary, secondary, and tertiary care, including public health.

Through Internet information about list of hospitals and their addresses, a comprehensive list of Doctor's in Vijayapura and Booking Appointments is accessible. Using the Internet to find health and medical information can help to be informed and take right decisions about our health, although some health information available on the Internet can be valuable. Internet users search for health information online, with increased interest in areas such as diet, fitness, drugs, health insurance, experimental treatments, and particular doctors and hospitals , to gather more information about a medically diagnosed disease or illness, to find out alternative medical treatments and seek support from other Internet users having the same kind of medical disease or illness via 'chat rooms', online discussion forums, blogs or communities, or social media such as Facebook, etc.

INFORMATION ON VARIOUS HEALTH SCHEMES

The government district hospital provides preventive, promotive and curative services for all the people in Vijayapura. There are many special units in the district hospitals of Vijayapura. The Government district hospital does not have its own website, the facilities, services and details are hence not accessible to the public.

There are certain schemes run and supported by the state and central governments, such as ESI, Vajpayee Arogyasri, Arogya Bhagyayojane, Yashasvini, Janani Suraksha, etc. Vajpayee Arogyasri is a unique health insurance scheme implemented by Government of Karnataka. The scheme provides financial assistance to urban poor families to meet their health needs. Serious diseases affecting heart, kidney, cancer, brain haemorrhage, burns and accident cases, etc., are covered under the scheme. Yashasvini scheme is open to all the members of the rural co-operative society. The Sthree Shakti scheme has been designed so that women belonging to BPL families can avail totally cashless treatment in private hospitals. Janani Suraksha scheme is the continuation of the previous delivery allowance scheme of the Central Government. The objective is to provide financial assistance to the poor pregnant women during delivery (Human Development Report, 2014). The Sukshema Project of the government is one of the health care projects in Vijayapura with a higher popularity among the people residing in the rural areas of Vijayapura. The information on these schemes available in various hospitals does not receive any mention on the websites even though these are State Government schemes, these schemes are not mentioned in the hospital websites.

CONCLUSION

The Internet access for health information is low. Compounding the situation is the poor delivery of health information services. Existing constraints to the Internet access might encourage quick check of health information without giving adequate attention to cross-checking or verifying the authenticity of the information from other sources. With the poor access and urge to quickly surf the Internet for health-related information, the chances are high that inadequate information may be sought. This shortcoming may strengthen further the practice of self-medication and delays in prompt health information seeking through formal sources. Furthermore, there is a need for practitioners in the Vijayapura city health sector to take an active position in providing timely and context-relevant information to the growing need for online health information. This also offers the sector an opportunity to take a lead position in regulating and ensuring the availability of health-related information, especially that which is related to local common health conditions. Such efforts will also complement existing initiatives aimed at improving

active participation of the Vijayapura city people in promoting and sustaining healthy practices [13].

There are currently several medical information websites that directly target the general population with the aim of providing information about health problems, self-care and prevention. However, this new technology also hides several shortcomings, such as: (i) uneven quality of medical information available on the Internet; (ii) difficulties in finding, understanding and using this information; (iii) lack of access for the unconnected population; and (iv) the potential for harm and risks of over consumption .To be able to overcome these dangers, it is important that public health practitioners and health professionals be involved in the design, dissemination and evaluation of Web-based health and medical information.

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Use of Libraries by Rural Women in Vijayapura District: A study

Shobha Patil

UGC-Post Doctoral Fellow, Department of Library and Information Science, Akkamahadevi Women's University, Vijayapura, Karnataka

P. G. Tadasad

Professor and Chairman, Department of Library and Information Science,Akkamahadevi Women's University, Vijayapura, Karnataka

Abstract: The library as information provision instrument is however comparatively recent phenomenon. This paper reviews the related literature and based on a survey of 120 rural women of 2 villages of Vijayapura district describes the characteristics of rural women and examines to what extent they make use of libraries.

Keywords: Libraries, Rural Women, Vijayapura

1 Introduction

Information, which is available in different formats – print, non-print and electronic in different categories – primary, secondary and tertiary and in different channels – formal and informal, plays a vital role in the overall development of a nation as a basic resource. It has long been recognized as an essential ingredient for the progress of civilization and society for all the times. Women an important component of a society – a least beneficiary in view of their illiteracy, limited exposure to the outside world, poor communication and expression abilities and very limited or no access to information sources find very difficult to use the information they require. The most essential step under the circumstances is to understand completely the information seeking behavior of rural women in their socio-economic and cultural contexts. Women are mainly reached by indirect methods, usually through extension services. Even if the information is made available to the woman, the willingness of her to change her ability to interpret and use information and the credibility of information are the key factors in making any impact of information on their well being [1].

2 Review of literature

A literature search made on LISA+ [2], LISTA [3], Emeraldsight.com [4], and subject bibliographies [5-11] indicates that number of studies have been reported. Tadasad and Yallappa [12] report, the results of a study conducted to know the information needs and gathering habits of rural community for identifying the role of rural libraries based on the interviews conducted using structured interview schedules with one hundred and seventy-eight people of Kusanoor village, Gulbarga district. Results of a survey by Kumbar and Biradar [13] reveal that among the public awareness of mass media is compared to the public library. Ukachi [14] focuses on rural women as information users in order to ascertain the information needs and information seeking behaviour of rural women. The barrier to information flow to them was also identified. The result showed that the rural women do not have access to adequate information because the libraries as well as the local government have been inefficient. Based on a study carried out Okunna [15] found out what communication media are used by rural women in Nigeria as sources of development. Seriki [16] describes a study of the information needs of the Ibillo rural community in Edo State, Nigeria who are largely engaged in cassava production. Makes recommendations for the provision of the required information for rural development and suggests that Nigerian library schools should integrate courses on rural librarianship into their curriculum. Frylink [17] focusing on the information needs of remote, rural users, reviews Australian initiatives to meet these needs. Innovative activities within the tertiary sector and the positioning of Curtin University of Technology and its Library and Information Service in particular are highlighted. Dasgupta [18] addresses the diverse facts that influence the information seeking behavior of women in India. She identifies the type of information women need, social factors, economic factors and familial norms and hierarchy. She also considers the role of the librarian and information professional, including well-developed modern library and information dissemination facilities, public libraries in the new information–seeking environment, and information/ communication centers at the rural level. Sen [19] feels that rural people are capable of using information and exploiting the same for their betterment, in spite of lack of traditional education and presence of infrastructural obstruction, which can be demonstrated from the acceptability of e-choupal, initiative of ITC Ltd. In this context rural libraries must reposition themselves in order to be a relevant agent in this developmental work.

Libraries can work as a switching mechanism between information and its users. A survey reveals that there is a very weak women member base of rural libraries. This implies that unless the acceptability of the rural libraries increases, the libraries cannot act as a successful agent of change. Hence she suggests for more interaction between rural libraries, and other developmental agencies and carrying the information to the rural women within the framework of standard library services. Jeevan [20] analyses the difficulties of the prevalent broadcasting oriented model of information dissemination for rural development and suggests pragmatic utilization of public libraries and school libraries to evolve an information oriented model based on the types, sources and channels of information for rural development and the major impediments for accessing information by the rural community.

3 Methodology and study population

The selections of sample respondents have been made from Vijayapura district. The present study was under taken in two villages – Toravi and Arakeri of Vijayapura District to find out to what extent the public libraries are used by rural women, various sources available in the libraries and the frequency of use by rural women of Vijayapura District of Karnataka state. Vijayapura is a border district of Karnataka state. Its earlier named was Bijapur and in 2014 it was renamed as Vijayapura. The list of five tehsils/blocks in Vijayapura district is as follows Bagewadi, Vijayapura, Indi, Muddebihal & Sindgi. There are 692 villages, 679 inhabited, 13 uninhabited and six statutory towns in the district. As per Census 2011, the total population of Vijayapura is 2,177,331. Out of which 1,111,022 were males and 1,066,309 were females. This gives a sex ratio of 960 females per 1000 males. As per Census 2011 out of total population, 45.4% people lives in Urban areas while 54.6% lives in the Rural areas. The average literacy rate in urban areas is 83.2% while that in the rural areas is 61.6%. Also the Sex Ratio of Urban areas in Bijapur Taluka is 982 while that of rural areas is 949. The overall literacy rate of Vijayapura district is 67.15 percent while the male & female literacy rate is 77.21 and 56.72 percent respectively [21].The population of the study consists of rural women in Vijayapura district. In Vijayapura district two villages have been selected for this study. From each village 60 respondents have been selected. Total 2 villages and 120 respondents have been chosen for this study. The research study undertaken is exploratory in nature aimed at knowing the current status of rural women in Vijayapura district. The data required for the study has been collected from primary as well as secondary sources. The primary data is collected through interview and observation method.

4 Results

Table 1 : General characteristics of rural women(N= 120)

Characteristics	Numbers (%)	Characteristics	Numbers (%)
Age		Languages Known	
Less than 25	11 (9.2)	Kannada	120 (100)
26 to 35	33 (27.5)	Hindi	25(20.8)
36 to 45	55 (45.8)	English	0 (0)
46 above	21 (17.5)	Marathi	2 (1.6)
Educational qualificatio		Telugu	1 (0.8)
Illiterate	82 (68.3)	Tamil	0 (0)
Primary Education	23 (19.2)	Income	
Secondary Education	11 (9.2)	No Income	52 (43.3)
Diploma, Degree	4 (3.3)	200 to 500	43 (35.9)
Category		501 Above	25 (20.8)
GM	56 (45.8)	Occupation	
OBC	29 (22.5)	Farmer	16 (13.3)
SC/ST	35 (31.7)	Business	5 (4.2)
Marital status		House wife	47 (39.2)
Single	23 (19.2)	Labour	52 (43.3)
Married	97 (80.8)		

Large number of rural women under study belong to the age group of 36 to 45 years (45.8%, N=55). More than a quarter of populations belongs to the age group 26 to 35 years (27.5%, N=33) and a small percentage belongs to less than 25 years (9.2%, N=11); Rural women under study have been categorized into different social classes like GM, OBC and SC/ST. It is found that the study population comprises of 45.8% of GM (N=56), 22.5% of OBC (N=29) and 31.7% of SC/ST (N=35) women. More than two third of women under study are illiterates (68%, N=82), 19.2% (N=23) of women have completed their primary education and 9.2% (N=11) have completed their secondary education. It can be analysed that more than 80.8% of women under study are married (N=97). Larger number of women (43.3%, N=52) who do not have any income and another larger number of women whose monthly income is Rs. 200 to Rs.500 (35.9%, N=43). 20.8% (N=25) of the women having more than Rs. 500 income. Women labours (43.3%, N=52) constitute a larger proportion of the study population. 39.2% (N=47) are housewives. Kannada being the state language is known to all women (100%, N=120). Only 0.8% of women know Telugu (N=1).

Table 2: Use of Public Library(N=120)

Use of Public Libr	Frequency	Percentag
Yes	6	5
No	114	95

Table 3: Library Membership

Library Members	Frequency	Percentag
Yes	3	2.5
No	117	97.5

From table 2, it can be analysed that a greater majority of rural women (95%, N= 114) do not use library. It can further be analysed that a very small proportion of women (5%, N=6) use library. Whereas from table 3, it can be analysed that only 2.5% (N=3) of women have become members of the library.

Table 4: Frequency of visit to library

Frequency of visit to library	Frequency	Percentage
Once a week	2	1.7
Monthly	1	0.8
Rarely	3	2.5
Never	114	95

Table 4 depicts the frequency of visit to library by rural women. 95% (N=114) women never visit the library. Among them only 2.5 % (N=3) of women visit library rarely, 1.7% (N=2) of women visit library once a week and 0.8% (N=1) of women visit library monthly.

Table 5: Preferred sources of information in libraries

Preferred sources	Frequency	Percentag
Books	5	4.2
Economics	0	0
Reference books	0	0
Handbooks	0	0
Magazines and journals	2	1.7
Guides	0	0
Newspapers	3	2.5
Novels	3	2.5

From table 5, it can be found that hardly 2.5% (N=3) of women under study prefer to read novels and newspapers. 4.2% (N=5) of women prefer to read books and only 1.7% (N=2) of women preferred to read Magazines and journals. This clearly indicates that rural women are not interested in using other sources of information.

5 Conclusion

The library as information provision instrument is however comparatively recent phenomenon. There is a very weak women member base in rural libraries. This implies that unless the acceptability of the rural libraries increases, the libraries cannot act as a successful agent of change. Hence it needs more interaction between rural libraries, and other developmental agencies and carrying the information to the rural women within the framework of standard library services. These calls for identifying different roles of the rural libraries – supplementary role, coordinators role, role of a friend, and role of input provider to the Government. Awareness of rural libraries has to be created through various outreach programs, the Department of Public Libraries, Government of Karnataka has to take vigorous and integrated programs jointly with NGOs in developing multipurpose rural library system. The rural community should be considered as an element, while planning the library organization and services. Rural libraries should always be supervised by professionally qualified persons to provide the right information to the right person. Library professionals should themselves join hands to come forward to improve the library services with the help of emerging ICT applications. Public Libraries may organize some seminars, informal talks, lectures, workshops, etc. on the various major issues. In these programmes, the specialists may be invited to interact with the public. These would be very much beneficial and attractive to the users of the public libraries. Information Resource Centres can plays an important role in supporting community development and transformation of rural people by offering access to information that raises awareness about development issues.

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